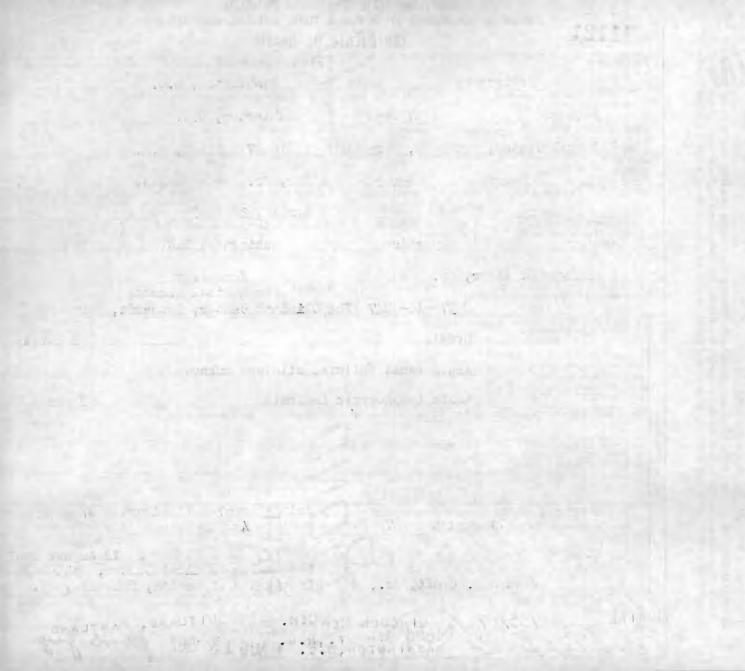
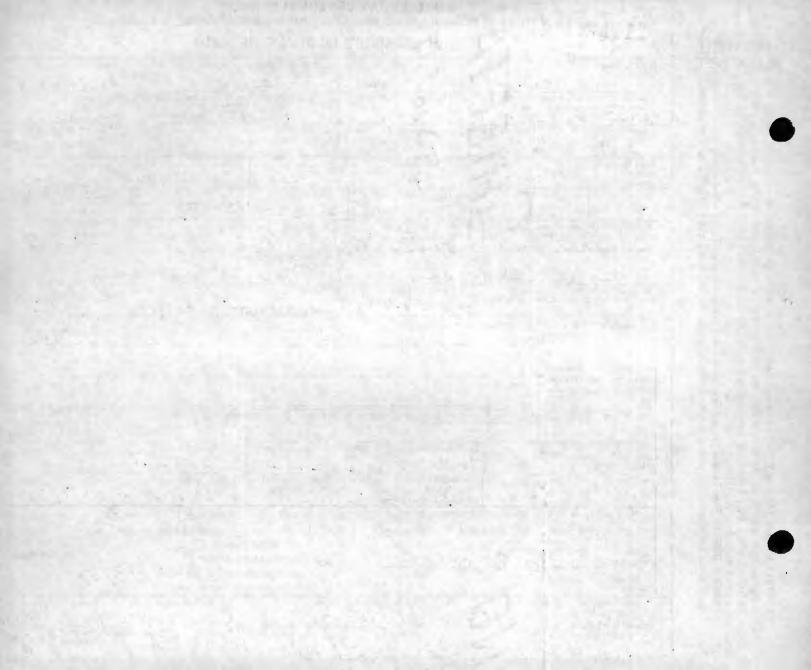


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed-within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b. COUNTY Montgomery Washington, D.C. MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lawn) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) Bethesda 27 Days Washington, D.C. e. IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS hin 72 The Clinical Center, Bethesda, Maryland 3816 17th Place, N.E. YES NO IX 3. NAME OF 4. DATE Year DECEASED Melvin Ailer, Jr (Type or pont) Lerov DEATH August S. SEX AGE (In years lost birthdoy) 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED Months WIDOWED DIVORCED Male Negro April 1936 puo 10o, USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** and IISA Teacher Education Washington, D.C. 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Melvin L. Ailer. Edna Frav 1S. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT The Medical Records (Yes, no, or unknown) (If yes give wor or dates of service) ŏ 579-46-5247 The Clinical Center. Bethesda. Maryland Yes cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONS AND DEATH IMMEDIATE CAUSE (o) Uremia weeks signed by the hospitol or attending physician. DHF TO Conditions, if ony, which gove (b) Acute renal failure, etiology unknown rise to immediate couse (a), **DUE TO** stoting the underlying cause this certificate has been as the (d) Acute Lymphocytic Leukemia vears PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES X NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 11 of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While of work **DIRECTOR:** After be retoined by 21. I certify that (M (this haspital) ottended the deceased fram 15 July , 19 67, to 11 August, 19 67, that (X (we) loss 1967, and that death accurred at 20 M, from causes and on the date stated above saw the deceased olive on 11 August 22n /SIGNATURE 22b. DATE SIGNED STAFF PHYS. X 12 August 1967 DIRECTOR M.D. director, page should be filed 22d. ADDRESS The Clinical Center. National 22c. PHYSICIAN'S O FUNERAL NAME (Type) Joesph D. Croft Institutes of Health, Bethesda, Md. Jr. MD 230. BURIAL/CREMATION, BURIAL (Specify) 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City of Town) (County) (State) 8/15/67 SUITLAND 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 WASHINGTON, D.C. DATAUG



9	MARYLAND STATE DEPARTMENT OF HEALTH						
Les X	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201						
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH						
HEALTH DEPT.	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, it institution: Residence before admission)						
lay is 13 ta Page ent af death.	a COUNTY MONTGONZETY_ MARYLAND O STATE Maryland b. COUNTY MONTGONE. TO						
fronty delay is I, 2, and 3 to am PM3. Page Department of Start St	b. CITY OR TOWN (If outside corporate limits, v. LENGTH OF STAY IN 1b c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest town)						
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	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?						
far far	ASTOC. NOTTIN. LEZYUE-						
s certificate shauld be executed within 24 haurs after death, s, writing the ward "pending" in pencil in-ltem 18. Give Page farwarded to the Chief Medical Examiner's Office along with tused as a burial-transit permit. File pages Land 2 with the State burial, cremation, ar remaval, and in any event writing to	3. NAME OF PIEST Middle Lost 4. DATE Month Day Year OF 173 1967						
Sive ng v	(Type or print) JO 177 05 Ander 50 NEVER MARRIED 8 DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS.						
wij wij	Manths Days Hours Min.						
haurs Item 1 Office and 2	10a. USUAL OCCUPATION (Give kind at wark dane 10b. KIND OF BUSINESS OR DIT BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT						
24 haurs a' in-ltern 18. r's Office ald	during great of working life, even investiged) INDUSTRY Luck Supply. Md. COUNTRY? J. J. a.						
thin 24 Puncil in-Ulumer's Capages 14 pages 14 in any e	13. FATHER'S NAME						
d within in pencil Examine File pag	James Anderson Mae Whisman.						
ed the leaf to the	IS WAS DECLASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or enknown) (If yes give war or dates of service)						
executed nding" ir Medical I permit.	(185, 10, or enknown) In yes give war or agree or service 218-34-703/ Mrs. Dores anderson That						
be execute "pending" hief Medical ansit permit	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSEIVARD DEATH						
shauld be e te ward "per a the Chief f burial-transit mation, ar re	IMMEDIATE CAUSE (a) C/03/124 // CCT.						
wante he he iden,	Conditions, if any, which gave) (b)						
he ta to the burnat	rise to immediate couse (a),						
ficate ing to ded as a as a	lost.						
certificate shauld , writing the ward arwarded ta the Cl used as a burial-tra burial, cremation,	PART II OTHER SIGNIFICANT CONDITIONS CONTRIRITING TO DEATH RIIT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ICO.						
This certificate shauld be executed within icate, writing the ward "pending" in pencil be farwarded to the Chief Medical Examine be used as a burial-transit permit. File page in to burial, cremation, or remaval, and in a	PERFORMED? 20a. EXTERNAL CAUSE WAS PRIMARY & or CONTRIBUTING CAUSE OF DEATH. The dose Plants of Performed? 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part III of item 18.)						
This ficate be for a d be ar to a	20a. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part IL of item 18.)						
UTY MECAL EXAMINER: This inty, please execute the certificate, tend director. Page 4 shauld be for your files. RAL DIRECTOR: Page 3 should be to or its designated agent, prior to	CAUSE OF DEATH. Troctor Plan Esuched Read against aute.						
AL EXAMINER: execute the certification of the certi	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, John County) (State) August 10 feb. 10 fe						
L EXAM ecute the Page 4 far your R: Page	1 of of of work of the						
Ar Page Area	21. I certify that I took charge of the remains described above, held on Autopsy, Inspection K_, Inquiry K_, and in my opinion						
ctar. ctar.	deoth resulted from: Natural couses , Accident , Suicide , Hamicide , Undetermined monner						
JIY M. A.	ACTUAL OL BOOK ACTIVAL EXAMINER 22. DATE SIGNED						
A Para	SIGNATURE M.D. ASSISTANT MEDICAL CARRINTER						
DEPUTY MECAL EXAM seessary, please execute th se funeral directar. Page 4 may be retained for your FUNERAL DIRECTOR: Page solith or its designated age	NAME (Type) DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)						
TO DEPUTY necessary, the funeral 5 may be r TO FUNERAL Health or ii	23a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23b LOCATION (City of Town) (County) (State)						
F - 1,51	Burel 8/15/67 St. Marya Barnesville Monty. Md.						
VR A15ME (5)	24. FUNERAL DIRECTOR ADDRESS						
6M 1/66	William Bernischt MI DATE AU 10 000						



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11124 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY a. STATE b. COUNTY b. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Maryland Maryland Nontgomery

CHY DR IDWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 event, within 72 hou 12hrs 5min Gaithershure d. NAME OF HOSPITAL DR INSTITUTION (If not in hospital, give street address) = d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NOX Montgome ry Cener a Boss 3. NAME OF corbon Middle 4. DATE Year Doy completely DECEASED (Type or print) DEATH Aug 1967 NEVER MARRIED AFUNDER I YEAR MARRIED 5. SEX 6. COLOR OR RATT 9. AGE (In years" IF UNDER 24 HRS lost birthdoy) Months Dovs Hours and in only WIDOWED DIVORCED 100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? ottending physician termit. Then please Live stock 13. FATHER'S NAME Maryland II.S.A 14. MOTHER'S MAIDEN NAME removal, Jefferson Charles ArMold
15. WAS DECEASED EVER IN U.S. ARMED FORCES? Emma 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 6 20-09 Mrs. Andrew J. Arnold cremotion, *18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH buriol-transit IMMEDIATE CAUSE (o) the hospital or attending physicion. DUE TO signed b burial, Conditions, if any, which gove rise to immediate cause (a), DUF TO stating the underlying couse State Dept. of Health prior to os the OR ATTENDING PHYSICIAN: The low lost. 19. WAS AUTOPSY PERFORMED? has PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES NO certificate of 20o. ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) DR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour o.m. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (Stote) (County) Not While factory, street, office bldg., etc.) While of work ot work TO HOSPITAL OR ATTENDING Poge 4 moy be retained by 21. 1 certify that (1) (this haspital) attended the deceased from. 1967, that (I) (we) last 8-12 19 67 to 8-13 saw the deceased alive an 8-13 19 67, and that death accurred at 2A M, fram couses and on the date stated above. 220. SIGNATURE ATTENDING M.D. DIRECTOR PHYS director, page should be filed 22c. PHYSICIAN'S 22d. ADDRESS TO FUNERAL NAME (Type) M. McKendree Boyer. M D. 23c. NAME OF CEMETERY OR CREMATORY 23o. 8URIAL, CREMATION, 23b. DATE THEREOF 23d. LOCATION (City or Town) (County) BEMONY (Specify) 8-15-67 Forest Oak Gaithersburg. Mont. 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Francis H. Barber Laytonsville, Md. 15

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11124

CERTIFICATE OF DEATH

11125

		CERTIFICATE	OI PLAIN		22500
	PLACE OF DEATH				an: Residence before admission)
	o. COUNTY	MARKING AND	o. STATE	b. COUN	
	b. CITY OR TOWN (If betside corporate limits,	MARYLAND	Maryland	Mon	taomery
	b. CITY OR TOWN (If abtside corporate limits,	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If out	side corporote limits, write RUR	(AL ohal give neorest town)
	write RURAL and give nearest town)	1 month	Sil	A. A	15-1
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospita		d STREET ADDRESS	prince	1 e. IS RESIDENCI
	a. NAME OF HOSPITAL OR INSTITUTION (IT NOT ITS HOSPING	, give street oddress)	d. SIREET ADDRESS	,	1404 ON A FARMS
	Orshinaton Sanita	num & Hospital	1220 8	Blair mill R	oad At YES NO
3.	NAME OF First	Middle	Lost	4. DATE Mont	
	DECEASED			OF O	
_	(Type or print)		Dagatti	DEATH HUQUE	
5.	SEX 6. COLOR OR RACE 7. MARRIE	D NEVER MARRIED	8. DATE OF BIRTH 191	9. AGE (in years)	IF UNDER 1 YEAR IF UNDER 24 H
	Mala Volita WIDOWE	D DIVORCED	7-27-180	lost birmady)	Manths Doys Hours M
	TIOIS WILLE			7 - 6263	10 CITIZEN OF MULAT
	. USUAL OCCUPATION (Give kind of work dane no most of working life, eyen if retired)	KIND OF BUSINESS OR INDUSTRY	II. BIK IHPLALE (COUNTY &	State, or fareign country)	12. CITIZEN OF WHAT COUNTRY?
0011		Restaurant	PENNASI	LUBRILL	U.S.A.
13.	FATHER'S NAME		14. MOTHER'S MAIDEN N	AME	
	1				
	Joseph Bagatti		Maria	ServEnt 1	
15.	WAS DECEASED EVER IN U.S. ARMED FORCES?	6. SOCIAL SECURITY NO. ZZ	INFORMANT	Addre	
[16	s, no, ar unknown) (If yes give war or dates of service)	214-05-5742	B. Ann Bagati	4 1220 Blair	Mill Road
			Pt. Recor	O. Selver Spe	ing Maryland
	18. CAUSE OF DEATH (Enter only one couse per line	for (o), (b), and (c).)	~ 1		INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY:	Christona of	1 tomach	- metartac	ONSET AND DEATH
	13 / X DUE TO				7 10 000
	Conditions, if ony, which gove)				
	rise to immediate cause (a),				
	stating the underlying couse DUE TO				
	lost. (c)				
		OT OTTAIN DUT TOW THE STATE OF	THE TERMINAL DIFFACE COM	NITION COVER IN DARK 1/-)	10 WAS AUTODSY
충	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING	5 TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONF	OHION GIVEN IN PAKE I(0)	19. WAS AUTOPSY PERFORMED?
CERTIFICATION					YES NO
3	20g. ACCIDENT WAS UNDERLYING [20b.	DESCRIBE HOW INJURY OCCURRED.	(Enter nature of injury in P	ort I ar Port II of item 18.)	
2	OR CONTRIBUTING CAUSE OF DEATH	PERSONAL HOTEL HOSEL OCCUMENT	famos nosoro as injury to t	and the state of the state of the state of	
0	(IF EITHER, NOTIFY MEDICAL EXAMINER)				
MEDICAL			CE OF INJURY (Home, form,	20f. (City or town)	(County) (State
탈	Hour o.m. 19		tory, street, office bldg., etc.)		
	J2.111 (1) W	vork U of wark U	~ /		
	21. I certify that (I) (this haspital) atte		7-15-6-19	108-15 6	7, 19, that (I) (we)
	saw the deceased alive an X-15		t death accurred at	M, fram causes	and an the date stated ab
1	220 SIGNATURE	3			22b. DATE SIGNED
	1000-1 CUL	NOTED MY		MED. STAFF	1 8-15-60
	72.068	-2600) . a.// W.		ALRECTOR L. PHYS. L.	10/30/
	22c. PHYSICIAN'S		22d. ADDRESS	111 (1)	>0- B 10-0.
	NAME (Type) James Whitle	ock. M. D.	171700	sof from 10	the office of
92-		23c. NAME OF CEMETERY OR	CDEMATORY	T 224 LOCATION (City or Tou	(Caustu) (Santa)
	BURIAL, CREMATION, 23b. DATE THEREOF			23d. LOCATION (City or Tov	wn) (County) (Stote)
19	rans-burial Aug 19, 196	7 St. Mary's C	emeteru	Cumberland 1	Maruland
24	TUNERAL OURECTOR AT A Plan Conta	ADDRESS	aca prob	BY REGISTRAR 256. RE	GISTRAR'S SIGNATURE
He	CTUNERS VOIRECTOR arter Chen Cinter	8434 Georgia Au	DATE ALL	G 18 1967 #	cores mayer
MINERAL PROPERTY.			W 11011 (W L)	A A WINDS	/ / CD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. **TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 And should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after deal and the state bear. Page 4 may be retained by the hospital or attending physician. VR A15 (4) 25M 1/67

- apper Day THE STATE OF THE PARTY OF THE P Denishary's that Is, Ist Ist. The Leading Committee, Ist Ist Ist Is The state of the s and the court of the

tems 18-21 Film 392 9-19-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DERT 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY b. COMNTY . any delay is 1, 2, and 3 ta the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 ta 4 shauld be farwarded to the Chief Medical Examiner's Office along with farm PM3. Page Prince the State Department c LENGTH OF STAY IN 16 outside corporate limits, write RURAL and give nearest town b CITY OR TOWN (If outside corporate imits write RURA, and give negrest team e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 YES NO De This certificate should be executed within 24 hours after death. NAME OF DATE DECEASED OF DEATH alamoti (Type or print) AGE (In years 5 SEX permit File pages 1 and 2 with lost b rthday) Months Dovs Hours 12 NOV. 1 and in any event within 72 haurs after death. WIDOWED 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Greece etired - Wai 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME Address 10434 ESGEFIELD 17 INFORMANT 16. SOCIAL SECURITY NO. (If yes give wor or dotes of service SOM JOHNNY M. BALAMOTI ADELPHI MD INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c)) burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY: Cardiorespiratory failure due to *MMEDIATE CAUSE (6) DUE TO Conditions if any, which gove Aspiration of castric contents (b) rise to immediate couse (a), DUE TO 0 stoting the underlying couse last. be used crematian, ar removal, 19 WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR! O 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port or Port I of Iem 18) 5 may be retained for your mes.

TO FUNERAL DIRECTOR: Page 3 should
Health prior to burial, cremation, ar in PRIMARY A or CONTRIBUTING Deceased vomited and aspirated gastric contents. MEDICAL EXAMINER: CAUSE OF DEATH (Stote) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) 6:00PMpm 8/17/679 Not While foctory, street, office b dg, etc.) Hvattsville Pr.Geo. Md. of work of work Home the funeral directar. Page 21. I certify that I took charge of the remains described above held an Autopsy XI Inspection X Inquiry M. and in my ap n'an death resulted from Natural causes Accident Suicide Homic.de Undetermined marrier CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE EMETERY RTLINCOLN 2Sb. REG STRAR'S SIGNATURE FUNERAL DIRECTOR VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. CDUNTY b. COUNTY Montgomery a. STATE Maryland Montgomery MARYLAND CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) hours Echo Heights Glen Echo Heights vears bon papers. within 72 h d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS IS RESIDENCE DN A FARM? Mohican Road 5445 5445 Mohican Road ND 5 YES! within letely completely ve carbon 3. NAME OF First Middle DATE Month Day TERRESPIE EBBBARRINGTON C. (Type or print) DEATH 19 and con 5. SEX 6. CDLOR DR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months | Days | Hours | Min. 7. MARRIED NEVER MARRIED âny Male White Mar. 26. 1892 WIDOWED I DIVORCED [7] Ξ 10a. USUAL DCCUPATION (Give kind of work done) sician lease r 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12, CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? U.S.Govt South Carolina attending physic ermit. Then plea U.S. death certificate Claim Examiner removal. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Martha Britt Ebb Barrington 15. WAS DECEASED EVER IN U.S. ARMED FORCES? the attendit permit. 16. SDCIAL SECURITYND. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Same as Item 2. WW 1577=34=2344 Vivian Barrington ned by the I-transit p II, cremativ CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN law requires that the PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Cenditions, If any, which peen gave rise to immediate the l DUE TO cause (a), stating the underlying cause last. PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT certificate h WAS AUTOPSY CERTIFICATI PERFORMED? ND V YES is certached for 208. ACCIDENT WAS UND REYING DE CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not While p.m. 19 at work at work the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: age 3 should iled with the 45 M5Hom the causes and on the date stated above. and that death occurred at // saw the deceased alive or 22a. SIGNATURE DATE SIGNED filed ATTENDING STAFF DIRECTOR M.D. PHYS HOSPITAL FUNERAL 22c, PHYSICIAN'S ADDRESS director, NAME (Type) should 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) 0 Maryland Parklawn Cemetery Rockville Burial -l5-67 24. FUNERAL DIRECTOR ADDRESS 25b. REGISTRAR'S 25a. REC'D BY REGISTRAR Bethesda, PUMPHREY. Maryland VR A15 (4) 20M 1/65



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY MARYLAND (If outside corporate limits, write RURAL and give nearly) town) B IS RESIDENCE ON A FARM? INSTITUTION (If not in hospital, give street address) d STREET ADDRESS NO. Firs1 DATE DECEASED OF DEATH (Type or print) (in years JNDER 24 HRS MARRIED burthdoy) Months Hours VII) WIDOWED 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT ond in physician (**COUNTRY?** INDUSTRY FATHER ST NAME 14 MOTHER'S MAIDEN NAME. burial, cremotion, or removal. 16. SOCIAL SECURITY NO INFORMAN' Address pp, or unknown) (If yes give wor or dotes of service 1B. CAUSE OF DEATH (Enter only one couse per la -transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) by the hospital or attending physician. DUE TO burio Conditions, if ony, which gove rise to immediate couse (a). DUE TO tor use as the L FHealth prior tab stoting the underlying couse lost PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART certificote 20o. ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (Stote) 20c TIME OF INJURY Month, Doy, Year (County) Hour o.m. factory, street, office bldg. etc.) 21. I certify that (1) (this haspital) attended the deceased from O HOSPITAL OR ATTEND Poge 4 may be retained and that death occurred at 5500 M, from causes and an the date stated above. O FUNERAL DIRECTOR: saw the deceased olive on 220 SHOWATURE ATTENDING director, page 3 should be filed a University DATLOW NAME (Type) Silver Spring, Maryl 23c NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23h DATE THEREOF 23d LOCATION (City of Town) (County) REMOVAL (Specify) Parklawn Cemeterv Rockville. Maryland 250. REC'D BY REGISTRAR 24 FUNERAL DIRECTOR Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11123 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution, Residence before admission) o COUNTY Montamera MARYLAND CITY OR TOWN AVOUTSIDE corporate timits. C. LENGTH OF STAY IN 16 If outside corporate limits, write RURAL and give nearest town te RURAL and give nearest down) impronuille NAME OF HOSPITAL SK INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? YES NO FIL NAME OF carbop Lost Year completely DECEASED Must Type or print 19 6 S. SEX NEVER MARRIED 9. AGE (In years 6 COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS (gst. birthday) Months Doys Hours DIVORCED | yna ni bno WIDOWED 1Db. KIND OF BUSINESS OR 10o USUAL OCCUPATION (Give kind of work dane 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of work no life, even if retired) ottending physicion (sermit. Then please INDUSTRY Washington, D.

14. MOTHER'S MAIDEN NAME House wife wn home 13 FATHER'S NAME burial, cremotion, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Groveleigh Drive (Yes, ng, grunknown) (If yes give wor or dotes of service) Eugene Alber None None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o) (b), and (c).) signed by the ONSET AND DEATH PART I, DEATH WAS CAUSED BY Coronary O Er lugaros IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gave rise to immediate couse (a). DUE TO os the prior to t stating the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTO USe PERFORMED? 3 should be detached for use with the State Dept. of Health YES 🗔 NO 🗷 this certificate 2Do ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2De PLACE OF INJURY (Home, form, (City or fown) 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED (County) (Stote) foctory, street, office bidg., etc.) Not While ot work **DIRECTOR:** After attended the deceased from _______, 19 44, to Queg 10, 1967, that (1) (we) last have 6 19 6 2 and that death occurred of 530 M, from causes and on the date stated above. 21. I certify that (1) (this haspital) attended the deceased from saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED DIRECTOR director, page 3 should be filed v MD 22c. PHYSICIAN'S 22d ADDRESS O FUNERAL NAME (Type James E. Nolan 230 BURIAL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) REMOVAL (Specify) Chestrut Grove Cemetery Herndon Virginia Sten Cotor 8434 PR Georgia Avenue VR A15 (4) 25M 1/67 Mullet J. S



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
11128 CERTIFICATE OF DEATH
PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before edmission)
a. COUNTY b. COUNTY
b. CITY OR TOWN III outside corporate lights to LENGTH OF STAY IN III
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVETS PRING HIFE SILVEY DPING
d NAME OF HOSPITAL OR INSTITUTION (if also in hospite), give street eddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
9209 Saubrook AVE 1209 Say 57-001 AVAYES NOV
NAME OF First Middle Lest 4. DATE Month Day Year
(Type or print) WILBUR THOMAS BEALL DEATH AUGUST 3 1967
170007
Market De Never Market De Never Market Dev House Mis
1618 Vy 1168, WIDOWED DIVORCED 1/22/8/7/1 5640.
00. USUAL OCCUPATION (Give kind of work long life, even if retired) 10b KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & Siete, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
Supervisor Post OFFICE Wagn. DC USA
3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
Thomas N. Boall Charlotte Schulte
5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address
Yes, no, or unkown) (lifyes give wer or dates of service) 218-24-037) Dorothy M Dozul 81112-C-17
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
IMMEDIATE CAUSE (6) CENTURIONA / 12 / 3 / 10 /
Contract of the second
Conditions, if any, which) (b)
geve rise to immediate couse (e), stating the underlying DUE TO
cause last, (c)
PART IS OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 19, WAS AUTOPSY PERFORMED? YES YES
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enfor nature of injury in Part I or Part II of item 18.)
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enfor nature of injury in Part II of flom 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
Hour e.m. While No! While factory, street, office bldg., etc.)
p.m. 19 el work at work
21. 1 certify that (I) (this hospital) attended the deceased from
saw the deceased alive on
226 SIGNATURE 226. DATE
William Tiland M.D. PHYS. ATTENDING MED. STAFF PHYS. SIGNED
22c. PHYSICIAN'S 22d. ADDRESS
NAME (Type) William D And MD Gook Colesville, Rd. Solver Spring
38. BURIAL, CREMATION, 23b. DATE/HEREOF 23c. NAME OF CEMETERY OR CREMATORY [23d. LOCATION (City, town or county) T (Stote)
REMOVAL (Specify) & / 1/17 Cata - 6/14
Bariel 8/7/67 Gale of Heaven Silver Spring Md
4 FUNERAL DIRECTOR'S SIGNATURE ADDRESS S//La 256. REGISTRAR'S SIGNATURE ADDRESS S//La 256. REGISTRAR'S SIGNATURE
VY C. Mimburs, Uno. Spring Monte AUG 7 1967 fellowles Judge

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11131 CERTIFICATE OF DEATH death. funeral gug PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after MARYLAND b CITY OR TOWN (If autside corparate limits c. LENGTH OF STAY IN 16 CCITY OR TOWN autside carparate firmits/ write RURAL and give nearest town) write RURAL and give negrest town d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCI ON A FARM? YES NAME OF Middle DATE carbon Year DECEASED OF DEATH (Type or pnnt) 19 S SEX AGE (In years 6. COLOR OR RACE NEVER MARRIED birthdoy) Haurs DIVORCED and 10b KIND OF BUSINESS OR 10p USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT during most all working life, even if retired) Hotel Business COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, 15 WAS DECEASED EVER IN U. ARMED FORCES?
(Yes, no or unknown) (II yes give war ar dates af service 17. INFORMANT 16. SOCIAL SECURITY NO Flanders Ave Walter E. Becker- son -Kensington. 50.09.3136 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) signed by the burial-transit (ONSET AND DEATH PART 1. DEATH WAS CAUSED BY: Uremia IMMEDIATE CAUSE (v) DUE TO Pycaephrosis and pyo-ureters, bilateral 3 mo if any, which gove rise to immediate cause (a). DUE TO stating the underlying couse 3 yrs Adenocareinowa, prostate gland has been 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES 🔼 NO 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II al item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (Cty or town) 20c TIME OF INJURY Month, Day, Year (County) (State) lactary, street, affice bldg., etc.) 21. 1 certify that (!) (this hospital) attended the deceased fram be retained 10 FUNERAL DIRECTOR: saw the deceased alive and 1967, and that death accurred at 15 AM, from causes and on the date stated above 22a SIGNATURI 22b. DATE SIGNED STAFF PHYS M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S O HOSPITAL W. Edmonston Drive, Rockville, Md. NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23a. BUR AL, CREMATION, DATE THEREOF 23d. LOCATION (City or Town) (County) BREMOVAL (Specify) 8/5/67 Laurel Memorial Park New Jerse 1 miness Rockville Pilke REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 25b. REGISTRAR S SIGNATURE Rockville, Maryland VR A15 (4) Tyson Wheeler Funeral Home 25M 1/67



STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF funeral S death. after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY a. STATE b. COUNTY Maryland Montgomery MARYLAND c. CITY DR TOWN (If outside corporate limits, write RURAL and give nearest town) Of outside corporate c. LENGTH OF STAY IN 1b write RURAL and give nearest town) hours Chevy Chase bon papers, within 72 h e. IS RESIDENCE filled [ITUTION of not in hospital, give street address) ON A FARM? 6919 Strathmore Street YES ND 3 etely completely DATE OF DEATH NAME OF Month Day Year Last DECEASED event, 1967 (Type or print) AGE (In Years IF UNDER 1 YEAR IF UNDER 24 HRS. iast birthday) Months | Days | Hours | Min. executed DATE OF BIRTH SEX 6. COLOR OR RACE 8. NEVER MARRIED 7. MARRIED гето any and DIVORCED WIDDWED sttending physician a mit. Then please re , or removal, and in 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) .= 10a, USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR during most of working life, even if retired) death certificate be FATHER'S NAME this certificate has been signed by the attending letached for use as the burial-transit permit. Then Dept. of Health prior to burial, cremation, or remov 17. Son A.Bentley - Ridgefield. George INTERVAL BETWEEN CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c) PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO (a), stating the underlying cause last. NO. WAS AUTDPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) detached for use e Dept, of Health PERFORMED? CERTIFICATI YES V ND F 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL (State) 20d. INJURY OCCURRED | 20s. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) 20f. (City or town) (County) 20c. TIME OF INJURY Month, Day, Year be de State Hour a.m. Not While OR ATTENDING I TO FUNERAL DIRECTOR: After director, page 3 should be should be filed with the State at work at work 21. I certify that (I) (this hospital) attended the deceased from icers that (I) (we) last and that death occurred at 5 2M, from the causes and on the date stated above. saw the deceased alive on DATE SIGNED 22a. SIGNATURE STAFF PHYS. ATTENDING neard le DIRECTOR M.D. PHYS. Page 4 may ADDRESS PHYSICIAN'S NAME (Type) (State) NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Arlington Natl Buria] 25a. REC'D BY REGISTRAR **FUNERAL DIRECTOR** PUMFHREY, Bethesda, Maryland DATIAUG VR A15 (4) 15M 4-64



	1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND					
	: = ~]	4	11136 CERTIFICATE OF DEATH	1133			
	24 hours after deafth. filled in by the funeral apers. Pages 1 and 2. n 72 hours after death.	4 I	PLACE OF DEATH HOLY CROSS HOSPIAL 2. USUAL RESIDENCE (Where deceased lived, If Institution: R	esidence before admission)			
	by the final by the final by the final bages 1 urs after	1_	MONIGOMERU MARYLAND PRINCE GE	orges v			
•	by the risal	0	b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
	Pour Pour Nour	\	d. NAME OF HOSPITAL ON INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	9. IS RESIDENCE			
			HOLY CROSS HOSPITAL 11354 Cherryhill Road	DN A FARM? YES NO NO			
	mpletely ent, within	3.	NAME OF First Middle Last 4. DATE Month DF OF	Day Year			
	comple care	5.	(Type or print) HDAM E. KERBER DEATH HUG.	1, 1967			
•	5 7 5 J	13.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IFUNDER last birthday) Months WIDOWED DIVORCED 7/15/67 yrs.	Days Hours Min.			
	E E E	10:	1. USUAL DCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11. BIRT HPLACE (County & State, or foreign country) 12. C	TIZEN OF WHAT			
	sicia leas and	100	ing most of working life, even If retired) INDUSTRY Holy CROSS HOSPITAL CO	U.S.A.			
	S salph ficat	13	FATHER'S NAME				
;	新 電車 電イン	Ì	HLAN L. BERGER WAS DECEASED EVER IN U.S. ARMED FORCES? 16, SOCIAL SECURITY NO. 17, INFORMANT Address				
		{ (Y	s, no, or unkown) (If yes give war or dates of service)				
	the de	-	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).1	INTERVAL BETWEEN			
;	the by the last the l		PART I. DEATH WAS CAUSED BY: Internal hydrocephalus	ONSET AND DEATH			
	that sicia med med al-tr		1/2/4 DUE TO				
	Phy Phy buri	1	Conditions, If any, which gave rise to immediate (b)				
	Green Been been been been been been been been	1	cause (a), stating the DUE TO				
	tten tten has as pric	음	underlying cause last.) (c) PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	119. WAS AUTOPSY			
	or a ste	CATI	Status post cerebral ventriculotomy, recent	PERFORMED?			
	PHYSICIAN: The law requires that the death certificate be the hospital or attending physician. This certificate has been signed by the attending physician detached for use as the burial-transit permit. Then please to Dept. of Health prior to burial, cremation, or removal, and it		20a. ACCIDENT WAS UNDERLYING TO DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18 OF EITHER, NOTIFY MEDICAL EXAMINER)	.)			
	s cerision solution of the series of the ser	\T		101-403			
		MEDICAL	factors street office bidg ata	inty) (State)			
	After Star	MA	p.m. 19 at work at work	That (I) (wa) last			
	rend aine oork oork the	1	21. I certify that (i) (this hospital) attended the deceased from	that (I) (we) last he date stated above.			
	S S S S S S S S S S S S S S S S S S S		22a. SIGNATURE 4	ATE SIGNED			
	N PE		pualian MWIlliams M.D. ATTENDING MED. STAFF DIRECTOR PHYS.	-2-67			
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician an director, page 3 should be detached for use as the burial-transit permit. Then please rep should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a		MANE (Type) Jouothan M. Williams 208 Pershing Dr. S.	wer Spr			
	Page Page direction	23:	BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or contempt of the contempt o	unty) (State)			
	F 2 "		Burial 8-7-6 Vall Mem. Vart Balls Purch	SIGNATURE			
	10 ALC (4)	24	4/1/ 2 /1/ 4217-5 th. AllG 7 1967 xchan	eles Judge			
	VR AI5 (4) 20M 1/65	12	dolberg runned Home M.W. O. C. DATE HOU!	0 0			
	1/ 1		<i>f</i>				



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death filled in by the funeral PLACE OF DEATH o. COUNTY MONTGOMERY 2. USUAL RESIDENCE (Where deceased lived, if institut an Residence before admission) a. STATE b. COUNTY Maryland physician and campletely filled in by the fur ien please remove carban papers Pages I aval, and in any eventamethin 72 hours after MARYLAND Montgomery c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 b CITY OR TOWN (If autside corporate I mits, write RURAL and give nearest town) Wheaton 3 weeks Rockville d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street oddress) d STREET ADDRESS e. IS RESIDENCE ON A FARM? Univ. Nursing Home 14106 Bauer Dr. YES NO x Wheaton. Md. Middle 4. DATE 3 NAME OF First iast Manth Day Year DECEASED OF August Nellie Bittinger 67 (Type or print Blanche 19 DEATH *IE UNDER 1 YEAR* IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (in years 7. MARRIED NEVER MARRIED Months last b rthday) Haurs WIDOWED 😾 DIVORCED 9/26/1890 Female White 76 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or fareign country) 12 CITIZEN OF WHAT Own home during most of working life, even if retired)
Housewife COUNTRY? USA Swanton, Md. attending physic permit. Then ple ion, ar remaval, a 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Francis Pritts Harriet Scooley WAS DECEASED EVER IN U.S. ARMED FORCES? 14106 Baner Drive 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, no, ar unknown) (If yes give war or dotes of service) 178-05-7452 Mrs. Verna Lindsay signed by the atter burial-transit perm burial, cremation, a No INTERVAL BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Canditions, if any, which gave rise to immediate couse (o). DUF TO stoting the underlying couse as the priar to O FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) MEDICAL CERTIFICATION detached far use te Dept. af Health NO YES -20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, form, (City or town) 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg . etc.) Hour a.m. Not While at work 196 1962, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram. director, page 3 shauld shauld be filed with the saw the deceased aliveran-19 6 and that death accurred at M, fram causes and an the date stated above. 22a. SIGNATURE 22b. DATE SIGNED STAFF PHYS. M.D. PHYS. DIRECTOR ADDRÉSS 22c. PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. DATE THEREOF Lafayette Memorial emeteru 2Sa. RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles ylen (ar VR A15 (4) DATAUG 1967 20 M 1/66 Silver Spring.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH deoth hours after deoth 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MARYLAND € LENGTH OF STAY IN 16 c CITY OR TOWN (If outside comprote imits, write RURAL and give nearest town) day IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not hospito, give street address) d. STREET ADDRESS papers. any Tevent, within 72 OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 filled i NO K corbon NAME OF Middle 4. DATE and completely **DECEASED** DEATH (Type or print) S. SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** AGE (in years lost birthdoy) WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT INDUSTRY COUNTRY physician (nen please during most of working life, even if retired) School leacher 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Robert H. Cook Minnie C. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service ö INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) signed by the buriol-transit p burial, cremotia ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO ed for use as the r . af Health prior to b stoting the underlying couse hos been lost. WAS AUTOP PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART PERFORMED? NO certificote 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port It of Item 18) 200 ACC DENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INTIRY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year O FUNERAL DIRECTOR: After this Hour 'o.m. foctory, street, office bldg., etc.) Not While ot work of work L.J 1962, that (I) (442) las 2]. I certify that (I) (this hospital) attended the deceased fram. 1965 be retained 1962, and that death accurred at 205 A.M. fram causes and an the date stated above saw the deceased alive on. 22b. DATE SIGNED 22n. SIGNATURE ATTENDING PHYS M.D DIRECTOR director, page should be filed filed 22d. ADDRESS 22c. PHYSICIAN S O HOSPITAL NAME (Type) 7.05 should LOCATION (City or Town) (Stote) 230 BUR AL, CREMAT ON. REMOVAL (Specify) 2SO RECD BY REGISTRAR 25b REGISTRAR S'SIGNATURE 25M 1/67 Funeral Home Silver Spring



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11135 CERTIFICATE OF DEATH death. guq PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) b. COUNTY Montgomery o. COUNTY Montgomery Marvland papers. Pages 1 hin 72 haurs after MARYLAND The law requires that the death certificate be executed within 24 haurs after c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest tawn) Bethesda. Bethesda d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? 4890 Battery Lane 4890 Battery Lane NOSE NAME OF Middle 4 DATE Lost Year DECEASED (Type or print) OF DEATH ELIZABETH BONHAG 10. Aug. 19 67 9. AGE (In years IF UNDER 1 YEAR | IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** 8. DATE OF BIRTH remaye 5 (st birthdoy) Days July 6. 1908 Female White and in any WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work dane 1Db. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY **COUNTRY?** Washington, D. C. S. Retired Govt 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar removal, Franklin C. Getzendanner Elizabeth Moffatt 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no. or unknown) (If yes give war ar dates of service 16 SOCIAL SECURITY NO 17. INFORMANT Husband Address Same as Item 2. 214-18-817*6* George A.Bonhag INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stoting the underlying couse last. WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NO DO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) 20a ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INTURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (Caunty) (State) 20c. TIME OF INJURY Month, Dov. Year Hour 'o.m. factory, street, affice bldg., etc.) at wark Page 4 may be retained by 21. I certify that (I) (this haspital) affended the decoased from director, page 3 shauld and that death accurred at 8-A M, from causes and on the date stated above. O FUNERAL DIRECTOR: saw the deceased alive an-22a. SIGNATURE M.D DIRECTOR 22d ADDRESS 22c PHYSICIAN'S WILLIAM L. HOWELL NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BUR AL, CREMATION, Burial Rockville Cemetery 8-14-67 Rockville. Maryland ADDRESS 25a. REC'D BY REGISTRAR 25b REGISTRAR S SIGNATUR 24. FUNERAL DIRECTOR **VR A15** PUMPHREY, Bethesda, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 1130 11137 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STA MEALTH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission) 2, ond 2 o. COUNTY o STATE b. COUNTY delay is and 3 to ₹ CITY OR TOWN/II outside corporate imit MARYLAND CITY OR TOWN (if outside corporate amits, write RURAL and give nearest town) Deportment c LENGTH OF STAY IN 16 e IS RESIDENCE ON A FARM? nospital, give street address) d STREET ADDRESS e, writing the word "pending" in penct in Item 18. Give Pages 1, forwarded to the Chief Medical Exominer's Office along with form State YES NO TX This certificate should be executed within 24 hours ofter death. NAME OF Maddle Lost Opy Year with the S DECEASED (Type or pont) DEATH 6 COLOR OR RACE AGE (In years IF JNDER 1 YEAR #F LINDER MARRIED NEVER MARR EO ost birthdov) Months Doys Hours event within 72 hours after death MIDOWED DIVORCED poges land2 B RTHPLACE (State or foreign country) 10b KIND OF BUSINESS OR 100. USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT during most of working life, even if retired) WDUSTRY Home West Virginia 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Delphia Patrick H. Cutt permit. File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or doles of service) Thauex 1Z_ INFORMANT HuenneAddress 16. SOCIAL SECURITY NO Eugene S. Borgman ues 18. CAUSE OF OFATH (Enter only one couse per line) INTERVAL BETWEEN burial-tronsit PART I DEATH WAS CAUSED BY ONSET AND OEATH IMMEDIATE CAUSE (o) OUE TO any Conditions, if ony, which gove (6) rise to immediate couse (a). _⊆ DUE TO stoting the underlying couse Ö last 00 used (cremotion, or removol, PART .I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) WAS AUTOPSY PERFORMED? CERTIFICATION the certificate, NO pe should be 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter notifie of in the not Lor Port II of item 18) 3 should PRIMARY Tor CONTRIBUTING T MEDICAL EXAMINER: CAUSE OF DEATH. 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or fown) (County) Hour o.m. factory, street, office bldg., etc.) your While Not While FUNERAL DIRECTOR: Page Page of work of work 21. I certify that I took charge of the remains described above, held an Autopsy [Inspection Inquiry and in my apinian burial, Natural causes director. death resulted from Accidem Hamicide Undetermined manner retoined CHIEF MEDICAL EXAMINER ACTUAL 22. OATE SIGNED ASSISTANT MEDICAL EXAMINER prior 1 SIGNATURE funerol þe DEPLIPY MEDICAL EXAMINER **EXAMINER'S** Health Address Substitute Barry or county) may NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o. BUR AL, CREMAT ON 23d LOCATION (City or Town) (County) (Stote) 0 Trans-burial Cresaptowen. Maryland St. Ambrose Cemetery 2Sb REGISTRAR S S GNATURE 250 REC'D BY REGISTRAR ADDRESS anten VR A15ME (5) Inc. 8434 Georgia Hvenne Pumphrey Thanks Judge 6M 1/67



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 h≡urs after death PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY o. STATE b COUNTY b CITY OR TOWN (If outside torporate limits, write RURAL and give negrest town) MARYLAND CLENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) .⊑ d. NAME OF HOSPITALOR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? NO 5 YES NAME OF Year DECEASED OF 26 (Type or print) DEATH S SEX DATE OF BIRTH 9. AGE (In years IF LINDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED lost birthday) Hours WIDOWED X DIVORCED UNC 25 1883 pup гел ond in on 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired)
POST OFFICE WORKER INDUSTRY COUNTRY? ALABAMA 11.5.0 Govt-retired 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, cremation, or removal, LIZA beth IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Daughter 30928 McKinley (Yes no prunknown) (If yes give wor or dotes of service) 423-42-1182 B. Adams Elizabeth Washington 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) INTERVAL BETWEEN transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) **DUE TO** signed t Conditions, if ony, which gove rise to immediate couse (a), **DUE TO** stating the underlying couse Page 4 may be retained by the hospital or attending etached for use as the Dept. af Health prior to last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO 55 20o. ACCIDENT WAS UNDERLYING . 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) Hour 'o.m. foctory, street, office bldg., etc.) Not While of work of work 1961, ta ling 26, 1967, that (1) (we) last 21. 1 certify that (1) (this hospital) attended the deceased fram_ Cury, 25 19 6 7, and that death occurred at 69 M, fram causes and on the date stated above. saw the deceased alive an 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR MD 22d. ADDRESS 746 K Street. 22c PHYSICIAN S O FUNERAL E. JOHN MORRIS NAME (Type) Washington. director, p 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23b. DATE THEREOF 23d LOCATION (City or Town) (County) Burial (Specify) Falls Church. Virginia 8-28-67 National Mem. Park 24. FUNERAL DIRECTOR **ADDRESS** VR A15 (4) 25M 1/67 PUMPHREY, Bethesda, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY Montgomery o. STATE Connecticut b. COUNTY filled in by the fun n papers. Pages 1 c ithin 72 haurs after d MARYLAND b CITY OR TOWN (If outside carporate limits write RURAL and give nearest town) r JENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) East Haven Bethesda 77 days d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 20014 e IS RESIDENCE ON A FARM? d STREET ADDRESS The Clinical Center, Bethesda, Maryland 3 Pevetty Drive NO DO 3 NAME OF and campletely to remove carban in any event, with Last 4. DATE Year DECEASED (Type or print) Jr. 21. 1967 Harrison Boyd. August Horton DEATH 6. COLOR OR RACE 7 MARRIED NEVER MARRIED XX 9. AGE (In years lost birthdoy) IF UNDER 1 YEAR | IF UNDER 24 HRS 8. DATE OF BIRTH Months Dovs Hours WIDOWED DIVORCED 30 July 1948 White Male 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Student 13 FATHER'S NAME Massachusetts 14 MOTHER'S MAIDEN NAME signed by the attending physi burial-transit permit. Then pl burial, crematian, ar remaval, Phyllis Bishop Harrison H. Boyd. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT The Medical Record Address The Clinical Center, Bethesda, Maryland 20014 No None 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c))
PART I. DEATH WAS CAUSED BY: myocardial INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (a) Multiple hemorrhages, subdural, gastrointestinal DUE TO signed b Conditions, if ony, which gave Aplastic Anemia, idiopathic 4 months rise to immediate cause (a). DHE TO stating the underlying couse TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been as been as the priar to b lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? YES NO [200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year Hour a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While ot work at work 21. I certify that (1) (this haspital) attended the deceased fram 5 June ne deceased fram 5 June , 19 67, to 21 August , 1967, that (t) (we) las 19 67, and that death accurred at 8:15 M, fram causes and an the date stated above director, page 3 should should be filed with the saw the deceased alive an Alignst 21 220 SIGNATURE 22b. DATE SIGNED ATTENDING STAFF PHYS. 22 August 1967 M.D. 22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md. 20014 22c PHYSICIAN'S David L. Lilien, MD. NAME (Type) 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) BEINDAM (SOUTHY) 8/25/67 Beaver Dale Mem. Pk. New Haven Conn. 24 PUNERA DIRECTOR Bethesda, Md. 2So. REC'D BY REGISTRAR Pumphrey VR A15 (4) DATE AUG 25

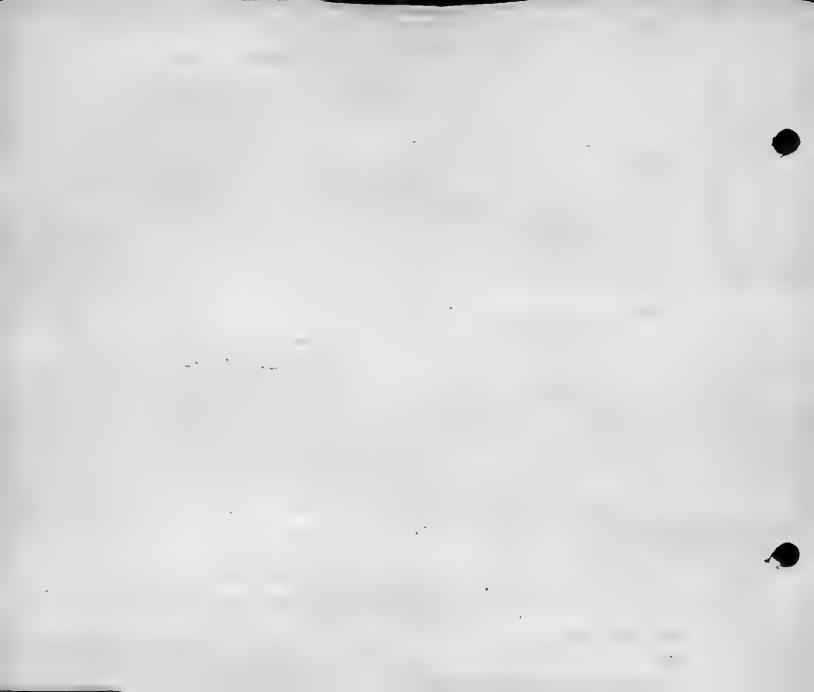
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 death. and 2 death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY < etely filled in by the furbon papers. Pages 1 a within 72 hours after d a. STATE b. COUNTY ontoomery Maruland MARYLAND Montgomeru b. CITY DR TDWN (if dutside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver UPGAA d. STREET ADDRESS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE DN A FARM? 1207 Ralland 1203 Ballard S ND X YES letely remove carbon r n any event, with 3. NAME OF First with Middle Last DATE Month Day Year DECEASED OF BRACEY 30 (Type or print) 16 USF DEATH 196 executed 5. SEX 6. CDLOR OR RACE 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. 7 MARRIED NEVER MARRIED Temale. WIDOWED A DIVORCED [7] August, 11 0 1876 physician and please revenue. .⊑ 1Da. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) death certificate be during most of working life, even if retired) INDUSTRY COUNTRY? dousewite Own Home Maruland 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending phy rmit. Then p n, or removal, Charles L. Maria Jurner Burch transit permit. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 1203 Ballard St. 17. INFORMANT (Yes, no. or unknown) | (If yes give war or dates of service) Parauerite Krown the INTERVAL BETWEEN been signed by the burial transit prior to burial, cremati CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).] The law requires that the ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). attending physician. DUE TO FRIOSCLEROTIC HEART Conditions, if any, which (b) gave rise to immediate DUE TD cause (a), stating prior ERACIZEN ARTERIOSCLEROSIS underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY Health I PERFORMED? certificate ND. YES 0, PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING TO DR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) this cerum detached for 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) CAL 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED 20e, PLACE DF INJURY (Home, farm, i 20f. (City or town) (County) (State) be de State factory, street, office bldg., etc.) Hour a.m. After While Not While retained by p.m. 19 at work ___ at work should ith the S 1960 AUG. 20, 1967 21. I certify that (1) (this hospital) attended the deceased from that (11) (we) last DIRECTOR: age 3 should led with the and that death occurred at A PM. from the causes and on the date stated above. saw the deceased alive on AU6 SIGNATURE 22a. þ page . ATTENDING MED STAFF M.D. PHYS. DIRECTOR PHYS. may HOSPITAL FUNERAL PHYSICIAN'S director, p 22d. **ADDRESS** SILVER SPRING. NAME (Type) w Md. 23a, BURIAL, CREMATION. 23b. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State 23d. 2 REMOVAL (Specify) 1967 wial Kock emeteru 24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE John, B arner DATE SEP Fineral Home VR A15 (4) reu 20M 1/65



1	MARYLAND STATE DEPARTMENT OF HEALTH
17	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
_	Items #5.6 & 7 FCERTIFICATE OF DEATH
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b. CITY	OR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give neares) tow
	write RURAL and give neeres! Journ
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	AME OF First Middle Last 4. DATE Month Dey Yeer
	ype or print) EVA - BRELOW DEATH /45. 4 19
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	1500- 70-
	TORAEL ZWEIG KEBECCA -
1	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT
	NO - UNKNOWN FORERT KOSENBLUM POCKVILLE, MO
-	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b,, end (c).]
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) ACUTE LEFT VENTRIC VIAK FAILURE ONSET AND E 30 MI
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INCL	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS A PERFO
446	YES _
N P	206. ACCIDENT WAS UNDERLYING 20b. DESCR.BE HOW IN.URY OCCURRED. (Enter neture of injury in Part I or Part II of item 18.) OP CONTRIBUTING CAUSE OF DEATH OF CONTRIBUTING AUSE OF DEATH OF CONTRIBUTING CAUSE OF DEATH OF
1 8	OF CONTRIBUTING LI CAUSE OF DEATH
1	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County)
1	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) Hour a m. While Not While 19 all work at work
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	21. I certify that (I) (this hospital) attended the deceased from RRII. 7, 1967, to It U.S. 4, 1967, that (I) (
	saw the deceased alive on A 19.7., and that death occurred at A.M., from the causes and on the date stated
	226. SIGNATURE 226 ATTENDING MED. STAFF 226
	Seal Paster M.D PHYS. DIRECTOR PHYS. 1 8/4/6
	22c PHYSICIAN S
	NAME (Type) ISRMEL KESS/ER M.D SEO1-16-St, NULL WASK, D.C
ć	23a BURIAL, CREMATION, 23b, DATE THEREOF 23c. NAME OF CEMETERY OF CREMATORY, 23d, LOGATION (City, town of county) (SI
9	
100	James State & State & Com Classic &
1 1 No.	THINK I SIGNATURE SIGNATURE ADDRESS OF STATE DESIGNATURE
	ADDRESS ACCIONAL SENTENCE ADDRESS ADDR



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution, Residence before admission) o. COUNTY b. COUNTY Page 6 CITY OR TOWN C. FNGTH OF STAY IN 1b ... outside carparate limits, write RURAL and give nearest tawns gud P.M3 Chase Deport d STREET ADDRESS S RESIDENCE ON A FARM? Examiner's Office along with form Apilene in Item 18 Give Pages NO X This certificate should be executed within 24 hours after death NAME OF Middle DATE Day Manth Year DECEASED OF N.M.N 30 (Type or print) DEATH 19 67 S SEX IF UNDER I YEAR 7 MARRIED AGE (In years FUNDER 24 HRS NEVER MARRIED last birthday) Months Days ony event within 72 hours after death. WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 12 C.T ZEN OF WHAT during most of working life, even if retired) INDUSTRY COLNIRY? in pencil ii 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME COMO I 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address 2808 Abilene rd "pending" ın Chief Medical E (Yes, na, or unknown) (If yes give war or dates of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) e, writing the ward forwarded to the Ch DUE TO Cardio Vascular Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse puo OS be used PART I OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) cremation, or removal, 19 WAS AUTOPS Y PERFORMED? CERTIFICATION NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW MULRY OCCURRED (Enter nature of injury in Port I or Part II of item 18.) 3 should PRIMARY OF CONTRIBUTING **EXAMINER:** CAUSE OF DEATH MEDICAL 20c TIME OF INJURY Month, Day, Yeor 20d NJURY OCCURRED 20e PLACE OF INJURY (Home, farm, 20f (City or town) factory, street, office bldg . etc.) moy be retained for your FUNERAL DIRECTOR: Page Not While ot work 21. I certify that I taok charge of the remains described above, held an Autopsy Inspection 💢 Inquiry [2]. and in my apinian Natura causes 🛪 Accident Suic de death resulted fram: Homicide Undetermined manner CHIEF MEDICAL EXAMINER prior to ACTUAL 22. DATE SIGNED ASSISTANT MED CA. FXAM NER SIGNATURE O DEPUTY necessory, DEPUTY MEDICAL EXAMINER John Health NAME (Type) Address (Street, city, town or county) BURIAL CREMATION 23c. NAME OF CEMETERY OR CREMATOR 23d LOCATION (City or Town) (County) (Stote) 0 KING DAVID MEMORIAL GARAGN CHURCH FUNERAL DIRECTOR 25b. REGISTRAR'S SIGNATUR VR A15ME (5) Y SONS-WASHING? 6M 1767



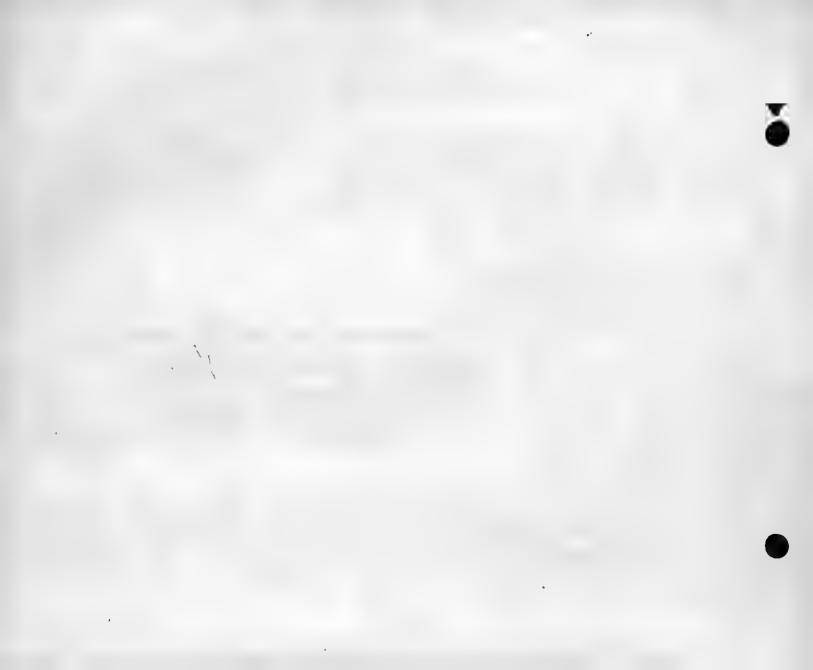
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 143 CERTIFICATE OF DEATH 142 The law requires that the death certificate be executed within 24 hours after death physician and campletely filled in by the funeral en please remave carban papers. Pages 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY A 190mer the attending physician and warpowy, papers. Pages I sait permit. Then please remave carban papers. Pages I was provided the please of the ple MARYLAND CLENGTH OF STAY IN 16 rside carporate limits, write RURAL and give neorest town MO.S IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) YES NO burial, crematian, ar removal, and in any event within. NAME OF First Middle 4 DATE Year Month Dov DECEASED 0F TRICC (Type or print) DEATH 19 6 SFX 6 COLOR OR RACE AGE YFAR IF UNDER 24 HRS (In veors 7 MARRIED NEVER MARRIED birthday) lost Months Hours Dovs WIDOWED DIVORCED 10h KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, eyen if retired) INDUSTRY 13. FATHER S NAME 14. MOTHER S MAIDEN NAME LUSS WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address burial-transit permit. (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN ONSET AND DEATH CAUSE OF DEATH (Enter only one couse per line for (o). PART I DEATH WAS CAUSED BY signed by t IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician DUF TO Conditions, if ony, which gove (b) rise to immediate couse (o). DHE TO stating the underlying couse this certificate has been director, page 3 should be detached for use as the shauld be filed with the State Dept. af Health priar ta WAS AUTOPSY PERFORMED? OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) CERTIFICATION YES 🗔 NO 20o ACCIDENT WAS JNDERLYING 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour o.m. Not While factory, street, office bldg., etc.) 19 ot work p.m. TO FUNERAL DIRECTOR: After __, that (I) (we) lost 21. [certify that (1) (this haspital aftended the deceased from M. from couses and on the date stated above. ond that geoth occurred of sow the deceased alive on. 220 SIGNATURE 22b. DATE SIGNED **ATTENDING** MED DIRECTOR M.D. PHYS 22d. 22c PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY LOCATION (City or Yown) CREMATORY 23o BURIAL (REMATION (Stote) LON REGISTRAR 1967 REGISTRAR'S SIGNATURE ADDRESS VR A15 (4) 20 M 1/66 (naw des



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death funerak ond PLACE-OF-DEATH 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o. COUNTY o STATE b. COUNTY papers. Pages 1 n.n 72 haurs after MARYLAND GOM ERY b CITY OR TOWN (if autside corposale limits write RUPAL and give nearest lown). OR TOWN (If outside corporate limits, write RURA. And give neorest C LENGTH OF STAY IN 16 INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENC ON A FARM YES NO NAME OF DATE Year Dov campletely DECEASED OF DEATH (Type or pant) even S SEX 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS remave ost birthdoy Months Doys Hours and in any WIDOWED DIVORCED and 10b KIND OF BUSINESS OR 100 JSUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 11 BiRTHPLACE (County & State, or foreign country) during most of working life, even fretired) physician INDUSTRY COUNTRY? ause w. 11.5.2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME crematian, ar removal, IS. WAS DECEASED EVER IN US ARMED FOR (ES? (Yes, no, or unknown) (U) yes give wor or dotes of service: 16 SOCIAL SECURITY NO INFORMANT permit. 18. CAUSE OF DEATH (Enter on y one couse per line for (a), (b) and (c)." INTERVAL BETWEEN burial-transit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) by the haspital ar attending physician. DUE TO signed bural Conditions, if ony, which gove rise to immediate cause (a). DUF TO stoting the underlying couse be detached far use as the State Dept. of Health priar to last has PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? NO. certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (Stote) (County) Not While Hour e.m. foctory, street, office bldg., etc.) ot work 21. I certify that (1) (this haspital) attended the deceased from ______ 10-29, 1967 that (1) (we) last , to A.C be retained AUG, 21, 1967, and that death occurred at 57 M, from causes and an the date stated above. saw the deceased alive on_ DIRECTOR: 22o SIGNATURE 22b DATE SIGNED **ATTENDING** M.D. PHYS PHYS r, page be filed 22d. ADDRESS 10 HOSPITAL Page 4 may b 22c. PHYSICIAN 6 TO FUNERAL director, shauld b LOCATION (City or Town) BURIAL, CREMATION (County) (Stote) 24 FUNERAL DIRECTOR ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11145 CERTIFICATE OF DEATH PHYSICIAN: The faw requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY b. COUNTY o. STATE Little Common A MARYLAND b CITY DR TDWN (if autside carparate limits, c. LENGTH DE STAY IN 16 c. CITY DR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest town) SILVER SPRING ll days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? event, within 72 filled ; MONTGOMERY GENERAL HOSPITAL 3711 Norbeck Road NO IT YES 3 NAME OF Middle 4. DATE carban First Last Month Day Year DECEASED Joseph Nathan Browning 1957 (Type or print) DEATH IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED last birthday) Manths Haues Min Negro Male 4-17-06 WIDOWED DIVORCED [12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) and in during most of working life, even if retired) physician (COUNTRY? Retired Georgia USA 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME or removal, George Browning Cammie Smith attending p 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give war or dates af service) 17 INFORMANT 16. SOCIAL SECURITY ND Address permit. cremation, 18. CAUSE OF DEATH (Enter anly one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY: signed by the burial-transit p ERMINAL MASSIVE HEMORRHAGE IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital ar attending physician. DUE TO burnal, ESUPHOGEAL Conditions, if any, which gave nse to immediate cause (a), DUE TO stating the underlying cause peen : as the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate has of Health p PERFORMED? YES 🗶 NO 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18) detached (IF EITHER, NOTIFY MEDICAL EXAMINER filed with the State Dept. 20e PLACE OF INJURY (Hame, farm, (City or fown) / (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED Haur am. factory, street, office blda., etc.) Not While OR ATTENDING at work **DIRECTOR:** After 21 I certify that (1) (this haspital) attended the deceased from _____ Mirram causes and an the date stated above saw the deceased alive an 1967, and that death accurred at 220 SIGNATURE DATE SIGNED 区 M D DIRECTOR director, page should be filed 22d ADDRESS PHYSICIAN S O HOSPITAL FUNERAL NAME (Type) Ur. Donald Levis 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 230 BURIAL, CREMATION, REMOVAL (Specify) 3-25-6 Harmony L ndover, Md. 9 250. RECORDER REDISTRAR 400 756. RECORDERS SICKLIFE 24 FUNERAL DIRECTOR **ADDRESS** Fraziers Washington, D.C. VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 1-146 OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. COUNTY a. STATE b. COUNTY Montgomery Ohio MARYLAND b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)
Bethesda c CITY OR TOWN (If autside carparate timits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 15 illed in by that papers. Page 36 Days Cuvahoga Falls d. NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street address) 2001. d STREET ADDRESS filled The Clinical Center, Bethesda, Maryland 1340 Hillcrest Drive.Apt.104 carban 3. NAME OF 4. DATE Manth Year DECEASED Marie (Type or print) Suzanne Brueggeman 19 67 DEATH August 5 SEX Female 6. COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthday) Months Haues and in any WIDOWED DIVORCED March 1946 White 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 1). BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Ohio None TISA 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME ar remayal, Robert E. Brueggeman Ernestine Nance 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT The Medical Record (Yes, pa, ar unknown) (If yes give war ar dates of service) 282-42-9517 The Clinical Center Bethesda Maryland burial, crematian, 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY 2 Days Bronchopneumonia. (Bilateral) IMMEDIATE CAUSE (o) to Lupus Nephritis 2 Months DUE TO Candit ons if any, which gave (b) Systemic Lupus, Erythematosus, with Uremia, due/ Years rise ta immediate cause (a), DUE TO stating the underlying cause last. 19. WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) PERFORMED? YES X NO F certificate 20a ACCIDENT WAS UNDERLYING IT 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Not While Haur Ta.m. factory, street, affice blda., etc.) at wark 21. I certify that (X) (this haspital) attended the deceased from June 27 19 67, to August 2, 1967, that (X) (we) last Page 4 may be retained saw the deceased alive an August 2 19 67, and that death accurred at 7:00 M, fram causes and an the date stated above. FUNERAL DIRECTOR: 22a SIGNATURE 22b DATE SIGNED STAFF 2 August 1967 directar, page 3 shauld be filed v attresser M.D DIRECTOR 4 anna 22d ADDRESS The Clinical Center, National 22c PHYSICIAN S NAME (Type) Henry B. Kaltreider, MD. Institutes of Health, Bethesda, Md, 2001/ 23d LOCATION (City or Town) BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (State) Bur Wat Specify) 8/5/67 Cuyohogo Falls. Northlawn Memorial Pkd 25p. REGISTRAR S SIGNATURE REGISTRAR 24. FUNERAL DIRECTOR ADDRESSWash D.C. VR A15 (4) Joseph Gawler's Sons 5130 Wisc. Ave NW DATE



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission o. COUNTY b. COUNTY MARYLAND b CITY OR TOWN (If autside carpetine c LENGTH OF STAY IN 16 c. CITY OR autside carparate limits, write RURAL and give negrest tawn) dopers. r. e. IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in Jospital, give street address) d. STREET ADDRESS filled NO F NAME OF carban, Erst East DATE Day Year and completely 3 DECEASED Marie Bruton (Type or print) DEATH 19 S SFX 9. AGE (In years) IE UNDER 4 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED **NEVER MARRIED** гетале lost birthday Months Days Hours WIDOWED DIVORCED 12 CIT ZEN OF WHAT 10a JSJAPOCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (County & State, or foreign/dountry) please during most of walking life, even if retired) INDUSTRY COUNTRY? 13 FATHER'S NAME MOTHER'S MAIDEN NAME ar removal, eu attending poermit. The IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) ((If yes give war ar dates of service INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c) signed by the burial-transit CAUSED BY IMMEDIATE CAUSE (a) Right & left ventricular cardiac failure, with ONSET AND DEATH PART I. DEATH WAS CAUSED BY hypertrophic and right ventricular dilitation Bilateral bullous pulmonary emphysema Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause has been the last. g PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 19. WAS AUTOPSY PERFORMED? (terminal) bilateral bronchopneumonia NO YES this certificate b 20g ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item IB.) the haspital OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month Day, Year (City or town) (County) (State) factory, street, office bldg., etc.) Haur a m Nat While at wark at work O FUNERAL DIRECTOR: After be retained by , 19___, that (I) (we) last 21. I certify that (I) (this haspital) attended the deceased fram shauld saw the deceased alive an M, fram causes and an the date stated above. , and that death accurred at 22a. SIGNATURE 22b. DATE SIGNED MED DIRECTOR PHYS. r, page 3 be filed v PHYS 22d. ADDRESS PHYSICIAN S NAME (Type) directar, shauld NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23b DATE THEREOF 23c LOCATION (City or Town) (County) (State) RPMOVAL (Specify) 24 FUNERAL DIRECTOR 2Sa. REC BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66

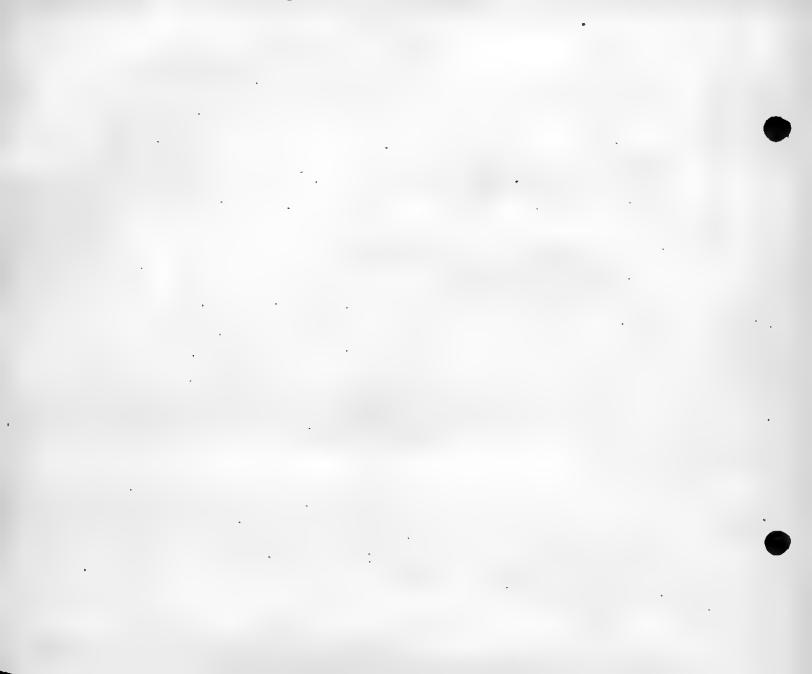


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11148 The law requires that the deoth certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission o. COUNTY Montgomerv b. COUNTY Florida MARYLAND b. CITY OR TOWN (If outside carporate limits, c LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write-SURAL and give nearest town) 20 days Sarasota d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? ve corbon popers filled Naval Hospital 270 Bearded Oaks Drive YES NO.A. NAME OF Middle 4 DATE Last Day Year DECEASED (Type or print) Joseph BURKE 18 Edward 1967 DEATH IF UNDER 24 HRS IF UNDER 1 YEAR S. SEX 6 COLOR OR RACE 9. AGE (n years - e 7. MARRIED NEVER MARRIFO B. DATE OF BIRTH last birthdoy) Months Hours in on 2 November 1907 Male Cauc WIDOWED DIVORCED and 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) **COUNTRY?** Larksville, Pa. USA 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME buriol, cremation, or removol Edward Joseph Briget Burke Connor 17. INFORMANT Chevy Chase 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, negar unknown) (If yes awe worker dates of service Adele F. Burke 4722 Cumberland Ave Md. Unknown INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH Cirrhosis, liver IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if ony, which gove (b) nse to immediate couse (a), DUE TO stoting the underlying couse detoched for use os the te Dept of Health prior to last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) YES 3d NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item IB.) 200 ACCIDENT WAS JINDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f (City or fown) (County) (Stote) 20c. TIME OF INJRY Month, Day, Year 20d INJURY OCCURRED Hour o.m. factory, street, office bldg., etc.) Not While of work to 8 August 1967, that (I) (we) last 30 July 21 I certify that (1) (this haspital) attended the deceased fram_ TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the saw the deceased alive an 18 August 1967, and that death occurred of 1515 M, fram couses and on the date stated above. 220. SIGNATURE 22b DATE SIGNED **ATTENDING** STAFF PHYS 18 Aug 1967 M.D. 22d. ADDRESS 22c PHYSICIAN S J.B. EMERY NAME (Type) Naval Hospital , Bethesda, Md. 23d LOCATION (City or Town) 230 BJRIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify) 8-22-57 Arlington National Arlington, Va. 25o. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) DATE AUG R.A. Pumphrey, 7557 Wisconsin Ave, Bethesda 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 11/0 PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. COUNTY MARYLAND b. CITY OR TOWN (if outside corporate limits, write BURAL and give means town c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest term) c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION OF Not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? NO L NAME OF Middle DATE Dav DECEASED (Type or print) DEATH ROPPIC HUGUS SEX ove 7. MARRIED NEVER MARRIED AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS last birthday) | Months | Hours WIDOWED DIVORCED [10a. USUAL OCCUPATION (Give kind of workdone) 10b. KIND OF BUSINESS OR during most of working life, even if retired) INDUSTRY hysician please 1 al, and in 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT 14. MOTHER'S MAIDEN NAME **a** = 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) [(If yes give way or dates of service) W.W. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: OL C IMMEDIATE CAUSE (a) DUE TO Cenditions, If any, which gave rise to Immediate cause (a), stating the as th prior underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY PERFORMED? NO N YES | 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work 21. I certify that (I) (this hospital) attended the deceased from 1940 to Face 19, 1967, that (1) (we) last 196 and that death occurred at saw the deceased alive on January M, from the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYSICIAN'S 22d. ADDRESS NAME (Type) BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) 24. FUNERAL DIRECTOR ADDRESS REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE £15 (4)



1	Items 18&21 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH 10-5-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11148 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
2, and 3 to PM3 Page HEATTH DEATTH Poge HITTER POGE HI	1 PLACE OF DEATH o. COUNTY OR TOWN (If autside carporate limits, dec. LENGTH OF STAY IN 1b) b CITY OR TOWN (If autside carporate limits, dec. LENGTH OF STAY IN 1b) c CITY OR TOWN (If autside carporate limits, dec. LENGTH OF STAY IN 1b) c CITY OR TOWN (If autside carporate limits, wirtle RURAL and give nearest town) d NAME OF HOSPITA. OR INSTITUTION (If hot in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? VES ON A FARM? VES NO DECEASED (Type or print) S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR) Months PORS House Months PAGE (In years IF UNDER 1 YEAR) Months PORS House Months Months PORS House Months Months PORS House Months Months Months PORS House Months Mont
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EXAMINER: This certificate shoul ute the certificate, writing the woring 4 should be forwarded to the your files Page 3 should be used as a bunol-cremotion, or removal, and in any	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO (c) PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMED? YES NO 200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING CONTRIBUTION CONTRIBUTIO
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after de_mth PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MONTCOMERY MARYLAND MARYLAND MONTGOMBRY b. CITY OR TOWN (If outside corporate lunits, write-RURAL and give nearest town) c CITY OR TOWN (If autside corparate firmits write RURA, and give nearest town) c. LENGTH OF STAY IN 16 in by ISETHESDA DETHESDA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? UBURBAN の世界 YES NO DZ UDC NAME OF Middle DATE Last Month Day Year DECEASED (Type or print) GRARGE Kowley 955100 DEATH S. SEX 6. COLOR OR RACE B. DATE OF BURTH AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdov Months Dovs ĎIVORCED WHITIE WIDOWED MALE JAN. 3 1898 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT ottending physicion of during most of working life, even if retired) INDUSTRY COUNTRY? MICHIGAN GOV. T. 1.51 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal 17 INFORMANT SOT WAS DECEASED EVER IN U.S. ARMED FORCES? 1701 KdreStreet. N.W. 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) 0 Washington, D. C. Yes WW John Cassidy cremation, INTERVAL BETWEEN IB CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) 4201 DUE TO Cardio Vascular Disesse burial, 4esis Conditions, if ony, which gove rise to immediate cause (a). DUE TO stating the underlying couse the hospital or offending lost. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health r PERFORMED? NO N certificate 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Part II of item IB.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home form, 20c. TIME OF INJURY Manth, Day, Year (City or town) (County) (Stote) Hour 'o m factory street, office bldg. etc.) Not While ot work 21. I certify that (1) (this haspital) attended the deceased fram. 1950 19____, that (I) (we)slas Page 4 moy be retained 1967, and that death accurred at 2 23 M, from causes and on the date stated above saw the deceased alive an 2 and TO FUNERAL DIRECTOR: 22c. SIGNATURE 22b. DATE SIGNED STAFF PHYS. M.D DIRECTOR 7936 Old Georgetown 22c PHYSICIANUS NAME (Type) 22d ADDRESS JOHN G. BALL Bethesda, Maryland 230 BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Arlington, Virginia 8-14-67 Arlington Natl Cem. Buria. 24 FUNERAL DIRECTOR 25b. REGISTRARS S GNATUR 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Charles PUMPHREY. Bethesda. Maryland



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 1. PLACE OF DEATH 1. COUNTY North Contract No
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20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) While Not While at work at work at work 21. I certify that (I) (this hospital) attended the deceased from 1. Aug 1967, to 23 Aug 1967 that (I) (we) last saw the deceased alive on 1. Seen 19 , and that death occurred at 1255M. From the causes and on the date stated above. 22a. SIGNATURE ATTENDING MED. PHYS. 23 Aug 1967
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.) 20c. TIME OF INJURY MONTH factory, street, officebldg., etc.)
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21. I certify that (I) (this hospital) attended the deceased from 12 Aug , 19 67, to 23 Aug , 19 67 that (I) (we) last saw the deceased alive on Not seen 19 , and that death occurred at 1255 M. From the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. PHYS. 23 Aug 1967
21. I certify that (I) (this hospital) attended the deceased from 10 Aug 1967, to 23 Aug 1967 that (I) (we) last saw the deceased alive on Not seen 19 , and that death occurred at 1255 M. From the causes and on the date stated above. 22a. SIGNATURE 22b. DATE SIGNED ATTENDING DIRECTOR PHYS. 23 Aug 1967
saw the deceased alive on Not seen 19, and that death occurred at 1255M. From the causes and on the date stated above. 22a. SIGNATURE ATTENDING MED. STAFF PHYS. 23 Aug 1967
22a. SIGNATURE 22b. DATE SIGNED 22b. DATE SIGNED 22b. DATE SIGNED 23 Aug 1967
John D Livereld mD Mr.D. ATTENDING MED. STAFF 23 Aug 1967
22c. PHOSICIAN'S NAME (Type) 22d. ADDRESS
John D. Griswold, M.D. 1 4930 V. St. N.W. D.C
23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
REMOVAL (Specify) Burial August 24 1967, Arlington Nationa Com Post Much Funeral Director Adoption State of
John B. Thomas Hend Home Silver Spring, Matte AUG 20 1961 Houries Judge



1		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
√ ≟ ≅∾≟		11153 CERTIFICATE OF DEATH 11154
death.	ī.	PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
94 /1		
24 hours after filled in by the apers. Pages and 72 hours after		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
hour I in S. 8		Silver Spring Silver Spring / /
24 fillectaper n 72	a	ON A FARM?
thin telly on p	3.	
executed within and exhibited by famove carbon is any event, within		(Type or print) Elizabeth J Cease Death August 31 1967
ave eve	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS last birthday) Months Oays Hours Min.
and		remale White WIOOWEO bd DIVORCEO 17/9/1875 92/rs. 1
cian d'ir	du	a. USUAL OCCUPATION (Give kind of workdone Industry) 12. CITIZEN OF BUSINESS OR II. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
ate hysi ple al, a	13	Housewife Pennsylvania USA L FATHER'S NAME 14. MOTHER'S MAIOEN NAME
rtific ng p Then move		Frederick Reymolds Leveinia Robbins
endi	1	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address es, no, or unknown) ((If yes give war er da les of service)
leath	L	Doretha Eckell
AN: The law requires that the death certificate be executed within 24 hours, pital or attending physician, ertificate has been signed by the attending physician and completely filled in by dof for use as the burial-transit permit. Then pleise formove carbon papers. Pag of Health prior to burial, cremation, or removal, and in any event, within 72 hours		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN DNSET AND DEATH DNSET AND DEATH
aat to Sian. Sid book tran		PART I. OEATH WAS CAUSED BY: ORDER - VOI WAY WAS AND DEATH
ss the hysical signaturial urial		Conditions, if ony, which I am Conditions of Carlos and
quire ng p sen to bu		gave rise to immediate cause (a), stating the OUE TO
w re endii s be rior	_	underlying cause last. (c)
e lar r att re ha	A TION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
al ou ficat for t	CERTIFICATION	YES NO W 20a. ACCIDENT WAS UNDERLYING 1 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Pert I or Part II of Item 18.)
CIAN Sspit cert ned t. of	CERT	20a. ACCIDENT WAS UNDERLYING CONTRIBUTION OF THE PORT
PHYSICIAN: The law requires that the hospital or attending physician. This certificate has been signed betached for use as the burial-transe Dept. of Health prior to burial, cre		20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)
fa P by ther ter tate	MEDICAL	Hour a.m. While Not While Factory, street, onice pidg., etc.)
NOT IN THE STATE OF THE STATE O		21. I certify that (I) (this hospital)/attended the deceased from to succeed, 1961, to 8/3/ 1962, that (I) (we) last
OR ATTENDIA be retained strector: At se 3 should led with the S		saw the deceased alive pn 19.51, and that death occurred at 3.5 M, from the causes and on the date stated above.
OR De la sed weed w		M.D. ATTENOING DIRECTOR STAFF PHYS.
TAL may		22c. PHYSICIAN'S 22d. ADORESS
PASPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician director, page 3 should be detached for use as the burial-transit permit. Then pleise should be filed with the State Dept. of Health prior to burial, cremation, or removal, and i		Dat con le del biten.
Pag Pag O Fl dire shot	23	a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) 9/4/67 Edgehill Cemetery Nanticoke Pa
	2	4. PARAL DIRECTOR AOORESS (25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
VR A15 (4)		Lee Funeral Home Washington, D. C. OATE SEP 3 1001 guartes jungles
20M 1/65	I=	



1	ı	Division of STATIST	MARYLAND STAT ICAL RESEARCH AND RECORD		'ARTMENT OF HEA W. PRESTON STREET		ND 21201	
•		11154	CERTIFI	CATE	OF DEATH		11155	
within 24 haurs after death. lely filled in by the funeral ban papers. Pages 1, and 9, within 72 hours after death,		CITY OR TOWN (If outside cornorate umits	OMERY MARYLU		O. STATE MARY	ere deceosed lived, if institution b. COUNT b. COUNT de corporate limits, write RUR	MONT.	
in 24 haurrilled in by papers. Phin 72 hour	,	write RURAL ond give neorest town) 1. NAME OF HOSPITAL OR INSTITUTION (If not			d. STREET ADDRESS R435 Z	BEL PRE 1	OAD YES	RESIDENCE N A FARM?
cacuted within 24 ho campletely filled in nave carban papers.		NAME OF JECKASED Type or print) EX 6 COLOR OR RACE EMALE WHITE	A ANGELINE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	- (B.	DATE OF BIRTH	4. DATE Month OF B P. AGE (In years lost birthdoy) P. AGE (In years year)	31 IF UNDER I YEAR IF	19 6 7 JNDER 24 HRS ours Min
ertificate be ex physician and nen please rem iaval, and in ag	dur	USUAL OCCIPATION (Give kind of work done not not of working I te, even if retired) HOUSE WIFE FATHER S NAME	10b. KIND OF BUSINESS OR INDUSTRY		BIRTHPLACE (County & S.	ORK STATE	12 CITIZEN OF WI	IS A.
e death certific attending phys permit. Then ian, ar remava p	îs.	0 1 - 1/	Service) 16 SOCIAL SECURITY NO. 220-54-2097	17. IN	ANGE. FORMANT AUGHTER		//	ove
physician. physician. signed by the burial-transit burial, cremati		rise to immediate cause (o), (stoting the underlying couse ((o) TERMINAL	you f.	CARDIAL	ISOHEH NGESTION		AL BETWEEN AND DEATH
ICIAN: The pital ar affer trificate has affer use a of Health pr	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CO PATHRITS 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		EM	PHYSENA -	· UREMIA	19. WA PER YES	S AUTOPSY RFORMED? NO
JING PHYS by the hos ifter this ce be detache State Dept.	MEDICAL	20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. 19 21. I certify that (1) (this has	While Not While of work of work deceased f	focto	F OF INJURY (Home, form, ry, street, office bidg., etc.)	20f. (City or town)		(Stote)
OR be re		saw the deceased alive an S 220. SIGNATURE and all all alive and alive alive and alive and alive alive and alive alive and alive alive alive alive alive alive alive alive and alive ali	Paris	M D	ATTENDING NO. PHYS. D	NED STAFF PHYS.	22b. DATE SIGNED	67 841
TO HOSPITAL Page 4 may FO FUNERAL director, page shauld be fi	230	NAME (Type) BURIAL CREMATON, REMOTESTED Sept.		ERY OR C	700 CLO	VERLY ST. 23d LOCATION (City or Tow Warrensburg		(Stote)
YR A15 (4) 20 M 1/66	24	Francis H, Barber	ADDRESS Laytonsville	M	2So. REC'D I	8Y REGISTRAR 2Sb. REG	SISTRAR'S SIGNATURE	1920

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11	1	It 10	ems 18&2 -2-67 am	l Film 393				RTMENT OF HEA		RYLAND 21201		
7	FOR STATE		11155			-		CERTIFICATE O			111	56
	HEALTH DEP	1.	NACE OF DEATH OCUMENTS ON TO SEE	rv		MAR	YLAND	2 USUAL RESIDENCE (0. STATE Mar	Where dec		ion. Residence be NTY Montg	
	f ony delay is 1, 2, and 3 to m PM3. Page bepartment of		CITY OR TOWN (If write RURAL and Takoma P	autside carparate limits, que nearest tawn)		c LENGTH OF STAY		Bethesda		arate limits, write RU	RAL and give nea	rest fawn)
	If any s 1, 2, orm Pi		NAME OF HOSPITAL	or Marilli on (II not in n Sanitarium		re street address)	5	d STREET ADDRESS		A		e IS RES DENCE ON A FARM?
	Poges with for	3	NAME OF DECEASED	Seet)	Last	Middle	,	5206 Elsm	4. DAT	E Man		Day Year
	ofter di 8. Give orong w with the	S	Type or print) SEX	Colling 6. COLOR OR RACE 7	MARRIED [Maria NEVER MARRIE	D B	Lucca L DATE OF BIRTH	DEA	0 100 /1-	IF JNDER 1 YEA	R IF UNDER 24 HRS
	thours of them 18. Office of land 2 wer death.	10a	USUAL OCCUPATION (White v Give kind of work done	VIDOWED [D OF BUSINESS OR	0 🗍	5-1-80	ar fareigr	87 AGE (In years 87 yrs	12 CITIZEN	OF WHAT
	within 24 hours of pencil in Item 18 xaminer's Office of the pages Land 2 whours after death		ng most af warking lil Housewi FATHER'S NAME		INDI	USTRY	- 1	CENTER'S MAIDEN		aryland	edin's	Y?A.
	I within n pencil		Friederic	h von Versen				Julia	III III III III III III III III III II	?		
	be executed within 24 hours ofter deoth. If a "pending" in pencil in Item 18. Give Pages 1, et Medical Examiner's Office along with forminsit permit. File pages land 2 with the State beant within 72 hours after deoth.	{Ye	s, no_ar unknawn) (I	IN U.5 ARMED FORCES? If yes give war ar dates of ser	5 7 7	00 AL SECURITY NO 7-46-768	30A	Hosp. C	hart	Addr	ess	
	word word the Ch riol-tro		PART I DEATH		Acu	te bronc ateral;	-	eumonia, eriosclero	tic			INTERVAL BETWEEN ONSET AND DEATH
	ficate through the red of the ond in the conditions on the conditions of the conditi		stating the underli		hea	rt disea	15 e					
	This certificate, writh	AT ON	PART OTHER SIG	HIFICANT CONDITIONS CONTE	RIBUTING TO	DEATH BUT NOT RE	LATED TO T	HE TERMINAL DISEASE CO	NDITION G	IVEN IN PART 1(a)		19 WAS ALTOPSY PERFORMED? YES NO []
	MINER: This the certificate, the certificate, a should be four fles. e 3 should be u e intion, or remointion, or remointing the certification of the certif	L CERTIFICAT	20a EXTERNAL CAL PRIMARY ☐ or CONT CAUSE OF DEATH		20b. DESC	R BE HOW INJURY O)((LRRED (Enter nature of njury in				
		MEDICAL	20c TIME OF INJUR Haur o.m. p.m	Y Manth, Day, Year 19	20d N. While at work	URY OCCURRED Nat While at work		E OF INJURY (Hame farr pry, street, office bldg., etc.		(City or tawn)	(Caunty)	(State)
	se exectors. Property of the form of the f		21. I certify death resulte	that I took charge of d from Natural co			_ /	de, Hamicide CHIEF MEDICAL	EXAMINE	Undetermined n	nanner 🗌	d 22. DATE SIGNED
	Y. P. Parall Drior		SIGNATURE	lden R. Rear	1 / (), M.D	1	ap_	M_D ASSISTANT MEI DEPUTY MEDIC Address (Stree	AL EXAMIN	ER 🛣	125/	1967
	necessor the fune 5 moy b TO FUNER Heath	230	BURIAL, (REMATION BULL (Specify)	23b. DATE THEREO 8-28-6		23c NAME OF CEA		Cemetery		tocation (City of to Suitland	Mary	land
	VR A 15ME (5)	24 R	OBERT A	PUMPHREY	. Bet	address thesda.	Mary	land 250 REC	BY SEGI	STRAR 25b. 2	ELISTRAR'S SIGNA	Judge



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY o. STATE b. COUNTY MARYLAND b. CITY OR TOWN (If gutside corporate timits CLENGTH OF STAY IN 16 c. CITY OR TOWN (If outside carpetote limits, write RURAL and give nearest town) papers. Pag write RURAL now <u>.</u> d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e IS RES DENCE completely filled in ON A FARM? YES NAME OF Middle DATE Lost Day Year DECEASED 0F event, 1 (Type or pont) DEATH 19 6 SEX 6. COLOR OR RACE AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR MARRIED NEVER MARRIED DATE OF BIRTH last birthday Months Dovs Hours Negro and in any WIDOWED DIVORCED gud On USJAL OCCUPATION (Give kind of work dane during most of working life even if retired) 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physicion (INDUSTRY 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME burial, cremation, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no ar unknown) (If yes give war at dates of service) 18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and PART I DEATH WAS CAUSED BY INTERVAL BETWEEN signed by the ONSET AND DEATH IMMEDIATE CAUSE (a) þ DUE TO Conditions, if any, which gove rise to immediate cause (a), **DUE TO** stating the underlying cause peen os the prior to O HOSPITAL OR ATTENDING PHYSICIAN: The low hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? detoched for use te Dept. of Health NO YES TO FUNERAL DIRECTOR: After this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) 20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home form, (E'ty ar town) (Caunty) (State) factory, street, office bldg . etc.) Not While at wark at wark 19 6 10 2, 19 (Ahat (1) (we) fas saw the deceased alive an_ 19 19 / Jand that death occurred at / M, from causes and an the date stated above 22a, SIGNATURE 22b DATE SIGNED STAFF director, page 3 should be filed v M.D DIRECTOR 22c. PHYSICIAN S NAME (Type) 230 BURIAS CREMATION DATE THEREO, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) ((ounty) (State) REMOVAL (Specify) WAY " (Form FUNERAL DIRECTOR REGISTRAR'S S GNATUR VR A15 (4) 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



								E, 18	158		
,			11157		CERTIFICA	ATE OF DEAT	Н	Reg. Dist.	No.		
d	1)	i PL o.	MONTE OMELY	Co	MARYLAND	2. USUAL RESIDENCE (V o STATE DIST. OF	there deceased lived. If in b. COL	Stitution: Residence b	pefare admission)		
	/	Ъ.	CITY OR TOWN (If outside of RURAL and give nearest tawn	corporate limits, write	c. LENGTH OF STAY IN 16		outside corporate limits, w	rite RURAL and give	nearest lawn)		
	- 1		SILVEY Spr	in4	~ ~~	WASHING	TON		47		
	,	d.	NAME OF HOSPITAL (IF not OR INSTITUTION	in hospital, give street	NURSING HOME	d. STREET ADDRESS	ARK SIDE LANE	· NW	e. IS RESIDENCE ON A FARM? YES NO		
9		DE	AME OF CEASED (pe or print)	First J.	DAVENPORT	Lost	4. DATE OF DEATH	Manth	Day Year 3 1967		
		54 SE	FL	WIDO	WED DIVORCED	8. DATE OF BIRTH APR'/ 2J.	9. AGE (In y lost birtho	lears IF UNDER 1 YI	EAR IF UNDER 24 HRS ys Hours Min.		
		100. l	JSUAL OCCUPATION (Give I luring most of warking life, e	even it retired)	b. KIND OF BUSINESS OR INDU	SW TZE	_ /	12 CITIZE	N OF WHAT COUNTRY?		
		13. FA	THER'S NAME	. /		TA. MOTHER'S MAIDEN		/	3 3 2		
			JOHN E.	ANdo	25	JUL:A	DUEKMA	N			
			AS DECEASED EVER IN U. S.	ARMED FORCES? I.	6. SOCIAL SECURITY NO. 17. 11 574-66 1481 78	LUERICK M. DAY	UNPORS- SON-	Address NE	WYORK N. W.		
		11	PART I DEATH WAS O		line for (a): [5), and (c).]	ary In	fact	C	NTERVAL BETWEEN ONSET AND DEATH		
			7504 Conditions, if ony, which	DUE TO	Generalez	ed ail	erewood	erosio o	20 years		
					, I	gave rise to immediate ause (a), stating the <u>under ying cause lost.</u>		and the	omboplel	ntes	d
	:	CATION			CONTRIBUTING TO DEATH BUT				PERFORMED? YES NO		
	1000				O. ACCIDENT WAS UNDERING CAUSE RECONTRIBUTING CAUSE FEITHER, NOTIFY MEDICAL		SCRIBE HOW INJURY OCCURRE). (Enter noture of injury in	Part I or Port II of item 18)	
		MEDICA 20	c. TIME OF INJURY Month, Hour o. m.		INJURY OCCURRED 20e. PL	CE OF INJURY (Home, for	m, 20f. (City or lawn)	(Cour	oly) (Slote)		
	- 1	≨	p. m.	19 While	ork al wark	lary, street, office bldg., et					
				19 at w	ark al wark	O, 19, ta	0-3- 19	6 Zthat I last	t saw the deceased		
		2	p. m.	19 at w	ark all wark are assed from 196	O , 19, to	9-3-, 19 9-M, from the caus		t saw the deceased date stated abave.		
		2	p. m.	19 at w	ark all wark are assed from 196	O , 19, to	9-3- 19				
1		2 o Asi	p. m. 1. I certify that I atta live an 7 - 2. CTUAL CTU	ended the deceded by 1921	ark all wark are assed from 196	O , 19, to	9-3- 19		date stated abave.		
1		2 0 A Si Pi N	p. m. 1. I certify that I atter live an	ended the deceded in 19,100 at wind and	ised from 196 ised f	accurred at 18:10 AD LC	2.M., from the cause ADDRESS (Street, city of particular) SULUPTA 22d. LOCATION (City, to	es and on the	date stated abave. DATE SIGNED		
1	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	A SI	p. m. 1. I certify that I attered to the live an	ended the deceded in the second in the secon	ised from 196 ised f	accurred of 2.10 AD LC CREMATORY Crematory	2.M, from the caus ADDRESS (Street, city of p	es and on the	date stated abave. DATE SIGNED PAGE SIGNED (Slate)		

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1,	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
= =(/ <u>/</u> /)	11158 CERTIFICATE OF DEATH 11159
after death, the funeral ges 1 and after death	PLACE OF DEATH a. COUNTY a. STATE b. COUNTY a. STATE
after the f ges 1 after	Maryland DC.
	b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE
ithin 24 horetely filled in both paper within 72 ho	Oakhaven Convalesce of Home 330, Prospect St. NW VES NO DE
<u>₹</u> #5 #5 #5	3. NAME OF DECEASED (Type or print) Kizabeth E Day DEATH Out 29 1967
executed wind and complete remove cardinals and event,	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (III. YEAR) IF UNDER 1 YEAR IF UNDER 24 HRS
in and c remov In any (WIDOWED DIVORCED 20.1887 78 yrs.
d Section of	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
phys phys ral, a	13. FATHER'S NAME 140 MOTHER'S MAIDEN NAME
ertifi ding The remo	? Gibbs UNKNOWN
death certificate ie attending physi permit. Then ple ion, or removal, a	15. WAS DECEASED EVER IN U.S. ARMEDFORCES? (Yes, no, or unknown) (If yes give war or datasof service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address
the attorn	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
that the sician. In the sician the sician that the sician site al., cremain	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) OR THE WAS CAUSED BY: OR THE WAS C
ires that the death certification. It is since by the attending burial-transit permit. The burial, cremation, or remo	Conditions, If any, which DUE TO Carlo Bran Andre
= 60 m = 0	gave rise to immediate (
i law requires that the attending physician, has been signed be a speed by a see as the burial-tranth prior to burial, creative to burial, creative to burial.	underlying cause last. (c) then brain broken - truck butter of lovet
The or cate	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO CONTRIBUTING CAUSE OF DEATH OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
PHYSICIAN, the hospital to this certification detached for the Dept. of H	20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.) CR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
ING PHYS I by the I After this be detact State Del	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hour a.m. p.m. 19 at work at work at work
retained by CTOR: After should be with the Star	p.m. 19 at work at work 21, I certify that (I) (this hospital) attended the deceased from 2 /26, 1957, to 8/, 1957, that (I) (we) last
TTEN etain TOR: shou th th	saw the deceased alive on 8/24/ 1967, and that death occurred at 112 M, from the causes and on the date stated above.
IAL OR A nay be r AL DIREC page 3 page 3	228. SIGNATURE ATTENDING MED. STAFF 226. DATE SIGNED M.D. PHYS. DIRECTOR PHYS.
TO HOSPITAL OR ATTENDING PHYSICIAN, Page 4 may be retained by the hospital TO FUNERAL DIRECTOR, After this certifi director, page 3 should be detached for should be filed with the State Dept. of H	PHYSICIAN'S NAME (Type) Chos H Wolotten 831 UNEWS, ty BIVI. E. S. (. Spring, Md
Page Page TO FU direct shou	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State)
0	24. FUNERAL DIRECTOR W/W C 12 m by ADDRESS (A/C) 25a. REG'D BY REGISTRAR'S SIGNATURE
VR AI5 (4) (7)	SOID MS F. W.W. Wash. D.C. DATEUG 3 1 1967 yellowles Judge
20111 1/00 4	



Division of STATISTICA		PARTMENT OF HEALTH 1 W. PRESTON STREET, BALTIMORE, MARYLA	ND 21201
5 11159	MEDICAL EXAMINER'S	CERTIFICATE OF DEATH	11150
PLACE OF DEATH Q. COUNTY	MARYLAND	2 USUAL RESIDENCE (Where deceosed wed, if institution of STATE b COUNTY	
b CITY OR TOWN (it outside corporate aways, write RURAL orde due nearest town	C LENGTH OF STAY IN 18	C CHTY OR JONNY (if outside eorporate 1 mits, write RURA)	gradgive neorest town
Suburhan	hospital, give street address)	3601 Southwise	S S RESIDENCE ON A FARM? YES NO
3 NAME OF DECEASED (Type or print) Mary C S SEX 6 COLOR OR BALE 7	MARPIED NEVER MARRIED		Doy Year 13 1967 1F UNDER 1 YEAR 1F UNDER 24 HRS
100 USUAL OCCUPATION (Give kind of work done during most of working life, even if refired)	VIDOWED D VORCED DISTRIBUTION OF BUSINESS OR INDUSTRY	11 BRIHPLACE (State or foreign country) Dist. of Columbia.	Months Doys Hours Min 12 CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Richard Dench	field,	14 MOTHER'S MAIDEN NAME Kathleen Carlson	
15 WAS DECEASED EVER IN US ARMED FORCES? (Yes, no, ar unknown) (If yes give wor ar dates of ser	none Mo	NFORMANT Address ther,(same as Item 2 a	
18 CAUSE OF DEATH (Enter on y one couse pot part I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)	er line for (o), (b), and (c)) Intestinal obstructions	ction	onset and death
Conditions, if ony, which gove (b) rise to immediate couse (a),		mal colostomy segment	24 hours
stoting the underlying couse DUE TO (c)	Imperforate amua,	congenital	20 month
PART I OTHER SIGNIFICANT CONDITIONS CONTR	BUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)	19 WAS AUTOPSY PERFORMED? YES X NO
200 EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH 20c TIME OF INJURY Month, Doy, Year Hour o'm.	206. DESCRIBE HOW INJURY OCCURRED	(Enter noture of injury in Part ! or Part II of item 18.)	
20c TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19		CE OF INJURY (Home, form, 20f (City or town) cory, street, office bidg , etc.)	(County) (State)
21. I certify that I taak charge af death resulted fram Natural co	the remains described above, he suses , Accident , Suic		
ACTUAL SIGNATURE OCHN SO EXAMINER'S JOHN G. E	Ball.	_M D ASSISTANT MEDICAL EXAMINER A S //	22. DATE SIGNED
NAME (Type) 230 BUR AL, CREMATION, 23b DATE THEREO		Address (Street, city, town, or county) CREMATORY 23d LOCATION (City or Town) (County)]V[d (Stote)
Burlal Aug. 16, 1	967 Ft. Lincoln	Cemetery. Prince Geor	ges County.



1 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
7.	CERTIFICATE OF DEATH	11161						
1 and 2 ter death.	1/10/1760 m EKY MARYLAND // 1ARYLAND	COUNTY PONT & OMERY						
hours af	b. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) 5/LUER SPRING LIFE SIZUER SPRING d. NAME OF HOSPITAL OR INSTITUTION (If nat in hasp tol, give street address) d STREET ADDRESS	5.1						
evenr, wirnin / 2	HOLY CROSS 12708 GOULL	8. IS RESIDENCE ON A FARM? YES NO						
	3 NAME OF First Middle Lost 4 DATE OF OF DECEASED (Type or print) CRAIG WILLIAM DICE DEATH A	Month Day Year UBUST 20 1967						
S.	S SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DIVORCED B. DATE OF BIRTH 9. AGE (In ye last burther B. DATE OF BIRTH 100 US JAL OCCUPATION (Give kind of wark done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country)	lay) Manths Days Hours Min.						
district dily	during most of working I te, even if retired)	COUNTRY?						
	BRUCEN DICE 14. MOTHER'S MAIDEN NAME CARLOHE LOC	UISE SHENK						
cremanan, ar remav	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no. or unknawn) (If yes give war ar dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT	Address						
	18 CAUSE OF DEATH (Enser only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Concolation & Respiratory faul	INTERVAL BETWEEN ONSET AND DEATH						
	Canditions, if any, which gave) DUE TO Congenital Malfaemateria (and	mellele;						
	rise to immediate couse (a), stating the underlying couse (c)							
. ,	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I	(o) 19. WAS AUTOPSY PERFORMED? YES NO						
	20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year Hour o.m. 20d INJURY OCCURRED While Not While foctory, street, office bidg., etc.) 20e PLACE OF INJURY (Home, farm, foctory, street, office bidg., etc.)							
	20c TIME OF INJURY Month, Day, Year Hour o.m. 20d INJURY OCCURRED While Not While of wark of octory, street, office bidg., etc.)	wn) (County) (State)						
	21. 1 certify that (I) (this haspital) attended the deceased fram \(Y - \frac{1}{2} \), \(19 \), \(\frac{1}{2} \) to \(\frac{19}{2} \) saw the deceased alive on \(\frac{1}{2} \) \(\frac{19}{2} \) (2), and that death occurred at \(\frac{1}{2} \) \(\frac{1}{2} \) M, fram ca	uses and an the date stated above.						
	220 SIGNATURE Lace HW Come M.D PHYS DIRECTOR PHYS	22b. DATE SIGNED 7.						
shauld be filed with the	22c. PHYSICIAN'S NAME (Type) WALLAGE H MC CANE M.D. 22d. ADDRESS 911 SILVER SPE	INGAUE. SILVERSp.M.						
0	230. BURIA., CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (Ging REMOVAL (Specify) 8/22/67 Gate of Heaven Cem Silver	or town) (County) (Stote) Spring Md						
M	24 FUNERAL DIRECTOR ADDRESS 250. RECD BY REGISTRAR	Sb. REGISTRAR S'SICHATURE						
(11)	Tyson Wheeler-Rockville, Md. DATEAUG 23 155							



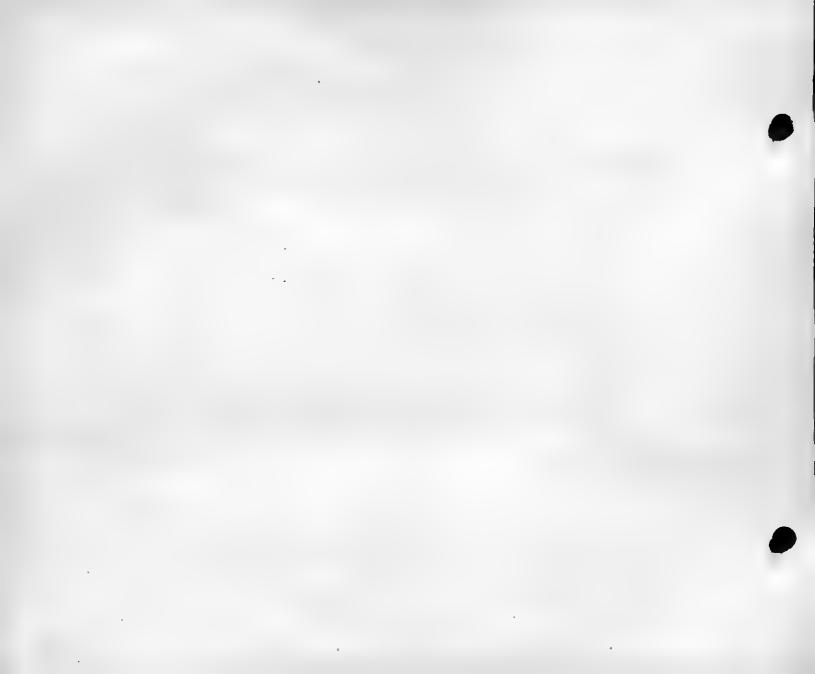
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11162 CERTIFICATE OF DEATH hours after deat PLACE OF DEATH USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) b county Montgomery o COUNTY o. STATE b. CITY OR TOWN (If outside carparate limits, MARYLAND law requires that the death certificate be executed within 24 haurs aff CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits, write RURAE and give negrest town) write RURAL and give nearest tawn d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS within 72 YES [NO A NAME OF Middle DATE First Day Year COMPON DECEASED 0F (Type or print) DEATH 19 L Bugus heoma S SEX 6 COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER I YEAR IF JNDER 24 HRS 7 MARRIEO NEVER MARRIED remave lost birthdoy) Months Doys Hours 6-25-90 Linker WIDOWED OIVORCED and 10b KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done 12 CIT ZEN OF WHAT 11 BIRTHPLACE (County & Store or foreign country) and in during most of working life, even if retired) COUNTRYS INDUSTRY. Marylano 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME burial, crematian, ar remaval, MATY Maurice Nowns CTTY INFORMAN 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Maloneu (Yes no, or unknown) (If yes give wor or dates of service) None necord Washing DALLAG NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) signed by the burial-transit PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stoting the underlying couse lost 50 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) has YES X NO certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Hour om foctory, street, office bldg, etc.) While Not While of work L ot work O FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from _______ 1967, that (1) (*) Just Page 4 may be retained and that death accurred of the M, from Causes and on the date stated above. saw the deceased alive on. 22q. SIGNATUR 22by DATE SIGNED ATTENDING DIRECTOR director, page 3 should be filed v M.D. PHYS PHYS 22d . ADDRESS PHYS CIAN'S NAME (Type) Harry N. Carlton 909 Pershing Dr. Silver Spring. 230 BURIAL CREMATION 23b DATE THEREO 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) Burial (Specify) Fort Lincoln Cemetery Prince Georges Co. Aug 9 2So. REC'D BY REGISTRAR 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11 12 13 13 13 CERTIFICATE OF DEATH 11162 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY a. STATE b. COUNTY Montgomery Maryland papers. Pages 1 hin 72 hours after MARYLAND Montgomery requires that the deoth certificate be executed within 24 hours after b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Kensingtom c CITY OR TOWN (If outside carparate limits, write RURAL and give negrest town) C LENGTH OF STAY IN 16 Kensington in by d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Aithin 12 completely filled 3905 Washington Street 3905 Washington Street NO X YES -NAME OF Middle 4. DATE remove carbon, Lost Doy Year DECEASED M. SARAH DINNEL (Type or print) DEATH August and in ony event, SEX 6. COLOR OR RACE 7. MARRIED 9 AGE (n years F UNDER 1 YEAR F JNDER 24 HRS NEVER MARRIED B. DATE OF BIRTH lost birthdoy) Months Hours White WIDOWED DIVORCED 2/9/30% Female puo 100 JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife 106 KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) ottending physician o sermit. Then please INDUSTRY COUNTRY? Maryland
14 MOTHER'S MAIDEN NAME TISA 13. FATHER'S NAME burial, cremation, or removal, Roderick Adams Katherine Hutton 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service 212-20-1209 Dr. Page T. Dinnel - Item # 2 signed by the a burial-tronsit pe 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN PART DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) - DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse TO FUNERAL DIRECTOR: After this certificate hos been director, page 3 should be detached for use as the should he filed with the State Dept of Health prior to O HOSPITAL OR ATTENDING PHYSICIAN: The law Page 4 may be retained by the hospital or attendin last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPSY PERFORMED? NO K YES 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER' 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF IN. URY (Home, farm, (City or town) ((County) Hour a.m. factory, street, office bldg., etc.) Not While ot work of work 2) I certify that (I) (this haspital) attended the deceased from May 1967 +1 perso 01 . 19 67), that (1) (we) last 19 57, and that death occurred at \$1.300 M, from causes and an the date stated above. saw the deceased alive an Oung 220 SIGNATURE 22b DATE SIGNED STAFF DIRECTOR M.D PHYS ADDRESS 22c PHYSICIAN S 8641 Colesville Poad, Lilver Spring, Md Blaine H. Eig NAME (Type) 230 BUR AL, CREMAT ON, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify)
Burial Brinklow, Montg., Md. Woodside 24 FUNERAL DIRECTOR
Pyson WheelerFuneral Home-1331 Rockville Pike AUG 250 REC'D BY REGISTRAR VR A15 (4) 25M 1/67 Rockville Md.



-//- I	1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 212	∤ 01 .
FOR STATE		### MEDICAL EXAMINER'S CERTIFICATE OF DEATH	11164
HEALTH DEPT.	1	PLACE OF DEATH a COUNTY Don Hamel () MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institut on Residence of County) MARYLAND MARYLAND	mury
Pages 1, 2, and 3 to with form PM3 Pige e State Department 72 hours after death.	1/3	b CITY OR DWN (I outside carparate mits, write RURAL and give write RURAL and give had been accepted to the control of the odd of th	e IS RESIDENCE
th (f) ges 1, 1 form 1 form haurs	-	NAME OF FIRST Middle Last 4. DATE March	CYLYES NO 12
2 8 E/ E =		DECEASED (Type or print) / homas DIXOD OF DEATH Cing	1967 YEAR IF UNDER 24 HRS
haurs after item 18. Giv Office along ian (2 mm the	13	rule white WIDOWED D VORCED 11/13/30 36 birthdays Months	Days Haurs Min
thin 24 haurs encil in Hem I miner's Office pages Tand 2 in any event	24	ring most of working life, even if retired) INDUSTRY Wash. (24	IZEN OF WHAT?
4 within 24 in pencil in Examiner's File pages and in any	13	FATHERS MANE STATES DIXON RADERS MAIDEN NAME Whales	2)
ecuted ng in edical E ermit. F	15 (Y	WAS DECEASED EVER IN J. S. ARMED FORCES? 16 SOCIA. SECURITY NO 17 INFORMANT Address es, no, of unknown) (If yes give wor or dates of service) 578-36-7782 MARC EDIXON - wy Same in #	2-
shauld be executed within te ward "pending" in pencil to the Chief Medical Examine burial-transit permit. File pag matian, ar remaval, and in c		18' CAUSE OF DEATH (Enter only one couse per line for (a), (b) and (c).) PART I DEATH WAS CAUSED BY. IMMED ATE CAUSE (a) Thyrooma L I T DUE TO	ONSET AND DEATH
IER: This certificate shauld certificate, writing the ward ould be forwarded to the Cles. shauld be used as a burial-truck prior to burial, cremation,		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
This certificate slicate, writing the be forwarded to libe used as a burial, cremo	CATION	PART I OTHER SIGNAL CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19 WAS AUTOPSY PERFORMED? YES TO NO
AMINER: This be the certificate, a 4 should be faur files. gg 3 should be a agent, prior ta	L CERTIFICATION		
■ を主める	MEDICAL	20c T ME OF INJURY Manth, Day, Year Hour a.m. 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, factory, street, affice bldg, etc) 4 factory, street, affice bldg, etc) 4 factory, street, affice bldg, etc)	anty) (State)
icarcal EXA icarca		21. I certify that I took charge of the remains described above, held an Autopsy . Inspection . Inquiry . death resulted from: Natural causes . Accident . Suicide . Homicide . Undetermined monner.	and in my opinion
please exploration of the property of the prop		ACTUAL SIGNATURE OF BOLK MD ASSISTANT MEDICAL EXAMINER ACTUAL SIGNATURE SIGNATURE ACTUAL SIGNATURE ACTUAL SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIGNATURE SIG	J 22 DATE SIGNED
TY, ergleral Se lo		EXAMINER'S NAME (Type) John G Ball Address (Street, city, town, or county)	1967
TO DEPU necessa the fun 5 may TO FUNEI Health o	23		(Caunty) (State)
VR A15ME (5) 6M 1/66	2	4. FUNERAL DIRECTOR ADDRESS 250 REGISTRAR 25b REGISTRAR'S SI PATE AUG 8 1967 FUNERAL DIRECTOR ADDRESS 250 REGISTRAR'S SI PATE AUG 8 1967 FUNERAL DIRECTOR DI	en Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11164 1105 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death. . PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Montgomery h COUNTY MARYLAND Montgomery b CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If guiside carparate limits write RURA) and give negrest town) Kensington Kensington d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street oddress) d STREET ADDRESS IS RESIDENCE ON A FARM? 4219 McCain Court Kensington Gardens Nursing Home YES NO TX campletely fi nave carbon I ny event, with 3. NAME OF Middle 4 DATE Month Last Veor DECEASED FEXXXXX FRANZICA OF DEATH August 18,1967 DOSS (Type or print) SEX 6 COLOR OR RACE B. DATE OF BIRTH E (In years IF UNDER 1 YEAR I IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 88t birthday) Nov.14,1878 Female White DIVORCED and in any WIDOWED 3 and 1Do USUAL OCCUPATION (Give kind of work done IDb. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, o. an country) COUNTRAS during most of working life, even if retired) INDUSTRY physician (Austria Housewife 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME burial, cremation, or removal, attending phys Unknown John Pfeifer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address permit. (Yes, no, orunknown) (If yes give wor or dotes of service) Fannie Tate 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p PART I DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause prior to l the (c) 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED? State Dept. of Health NO certificate 草 2Da ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 2De PLACE OF INJURY (Home, form, (City or town) (County) (State) 2Dc. TIME OF INJURY Month, Day, Year **FUNERAL DIRECTOR:** After this Hour a.m foctory, street, office bldg, etc.) Not While at work at wark 18 , 1967, that (1) (we) last 21 | certify that the haspital) attended the deceased fram Page 4 may be retained director, page 3 snavio should be filed with the 19 6 7, and that death occurred at 1 A.M. fram causes and an the date stated above saw the eceased alive 'an 226 DATE SIGNED 22a. SIGNATU ATTENDING M.D. DIRECTOR 22d. ADDRESS 22r. PHYSICIAN S O HOSPITAL NAME (Type) 852 - 16th. St., N.W., Washington, D.C. Franklin H. Kreuzburg 23g BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) REMOVAL (Specify) 8/19/67 Cremation Cedar Hill 250. REC'D BY REGISTRAR 256 REGISTRAR Funeral Home-1331 Rockville Pike VR A15 (4) 25M 1/67 Rockville, Md



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11165 11166 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) O. COUNTY MONTGOMERY b. COLUNT MARYLAND MARYLAND b CITY OR TOWN (If autside porparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If guitside carparate limits, write RURAL and cave negrest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs af ours (20 HRS -BeTRESDAd. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS B IS RESIDENCE ON A FARM 3 filled i SUBURBAN KOSSMORE NAME OF DECEASED Middle DATE Month campletely i nave carban, First East Doy Year (Type or print) 19 67 DEATH 9. AGE (In years last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED **NEVER MARRIED** Manths Days Haurs WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) physician (Own None COUNTRY? LRELAND 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME remova WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) ö 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) by the haspital or attending physician. DUE TO Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse be detached far use as the State Dept, of Health priar ta 19. WAS AUTOPS PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) this certificate has PERFORMED? YES [NO 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (C ty or town) (County) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, Haur a.m. factory, street, office bldg., etc.) Not While at work at wark 1956 21. I certify that (1) (this haspital) attended the deceased fram JAN ta AUZ 12, 1967, that (1) (we) tos and that death occurred of 2 M. from causes and on the date stated above O FUNERAL DIRECTOR: sow the deceased alive an AUG 22a SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN S O HOSPITAL MISCONSINAN NAME (Type) 23d. LOCATION (City or Town) 23b. DATE THEREOI 23c NAME OF CEMETERY OR CREMATORY (State) 230 BUR AL, CKINGALAGIN, (County) ACPROCACION DECITY St. John's Cemetery Maryland Forest Glen. 250 RECT BY REGISTRAR ALIG 1 7 1967 VR A15 (4)





			Division of STATIST	FICAL RESE	ARCH AND RECORDS, 3	301 W. PRESTON ST	REET, BALTIMO	DRE, MARYLAN	ND 21201	
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death.	1. 1	LACE OF DEATH	 			2. USUAL RESIDENCE	(Where deceased	lived, if institution:	Residence before	admission)
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ers.	'	I. NAME OF HOSPIT	AL OR INSTITUTION (If no	at in haspital,	give street address)	d. STREET ADDRESS			е.	IS RESIDENCE ON A FARM?
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs offer, death, etained by the hospital ar attending physician. CTOR: After this certificate has been signed by the attending physician and campletely filled in by the functal should be detached for use as the burial-transit permit. Then please remave carban pupers. Pages and 2 with the State Dept. at Health priar to burial, crematian, or removal, and in any event, within 72 hours after death		NAVA	L HOSPITAL			2910	R ST	N.W.	YE	S NO 👽
within ban kith		NAME OF	Aller and the second se	rst	Middle	rast	4. DATE	Manth	Day	Year
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re m s m s m s n o t o t o	П	stating the unde	rlying cause DUE							
daw odir or i		last.	,	(c)						
A ATTENDING PHYSICIAN: The faw re retained by the hospital ar attending ECTOR: After this cerificate has been 3 shauld be detached far use as the with the State Dept. af Health priar to be with the State Dept.	z	PART II. OTHER SI	GNIFICANT CONDITIONS Q	ONTRIBUTING	TO DEATH BUT NOT RELATED T	O THE TERMINAL DISEASE (CONDITION GIVEN I	N PART 1(a)	19. V	VAS AUTOPSY Performed?
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the Detector	WED	Haur a.c	n.	While	Not While	factary, street, affice bidg., e	tc.)			
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R A A	П	220. SIGNATURE	1/2 -	1-7	R - 101	ATTENDING	MED.	STAFF	ZZD DATE SIGNE	•
OR be r			Thuma	L	Jegus Killy	M.D. PHYS. 22d. ADDRESS	DIRECTOR L	PHYS.	9 AUGUS	T 1967 -
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HO:	23a	BURIAL, CREMATIC	ON, 23b. DATE TH	ERFOF	23c. NAME OF CEMPTERY	OR CHEMATORY Cres	na ory	TON (City ar Town)	(Caunty)	(State)
OS O P R	F	URIAL -C	remation	A 11/	91& OAK HITT.T.					
x x	24	. FUNERAL DIRECTO	IR JVI DO	NINE	ADDRESS	25a. Ri	C'D BY REGISTRAR	2Sb. REGIS	TRAR'S SIGNATURE	
VR A15 (4)	I	EVOL FUN	ERAT. HOME	2222 1	TECONSIN AVE	NW. WDChate A	JIG 7 1 1	967 RC	lianter &	udgl.

MARYLAND STATE DEPARTMENT OF HEALTH

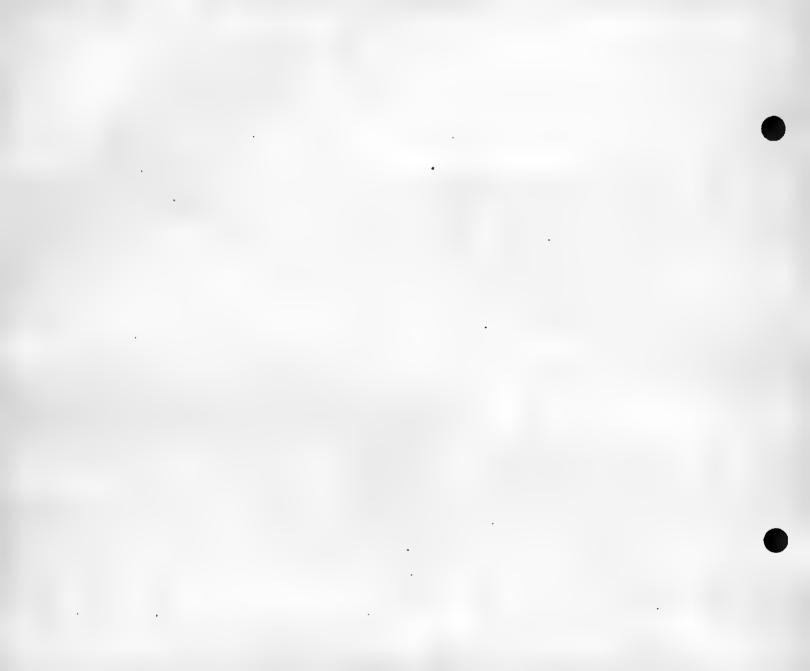




MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11169 MEDICAL EXAMINER'S FOR STATE HEALTH-DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a COUNTY **b** COUNTY MARYLAND b (ITY OR IOWN (If outside corporate limits, LENGTH OF STAY IN 16 corporate limits, write RURAL and give nearest town? after not in hosp to, give street oddress d STREET ADDRESS IS RESIDENC hours ON A FARM Stote YES 3. NAME OF Middle DATE Lost Doy DECEASED OF Within Type or print DEATH olong S SEX AGE NEVER MARRIED Months Dovs Hours DIVORCED event 06 KIND OF BUSINESS OR 12 CITIZEN OF WHAT (State or foreign country) COUNTRY? -Freque Examiner 13. FATHER'S NAME E puq INFORMANT 17 removal. INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per pa ONSET AND DEATH PART I. DEATH WAS CAUSED BY ŏ IMMEDIATE CAUSE for word certificate shourd cremation, DUE TO purior Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse forwarded 90 lost. PART I OTHER'S GNIFICANT CONDITIONS CONTRIBLENG TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE COND TON GIVEN N PART (c) 19 WAS AUTOPS)
PERFORMED? plic NO certificate 200 EXTERNAL CAUSE WAS PRIMARY ★ OF CONTR BUT NG □ CAUSE OF DEATH OCCURRED? (Enter noture of in any @ Port_) prior should MEDICAL T ME OF NJURY Month, Doy Year 20d INJURY OCCURRED 20e PLACE OF INJURY Home form. (City or town) (County) foctory street off ce hide, etc. While Not While DIRECTOR: Page designated 21 I certify that I took charge of the remains described above, held an Autapsy Inspection X induity for and in my opinion the funerol director. death resulted from: Natural couses Undetermined manner retoined ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE FUNERAL O DEPUTY may b TO FUNEI Health 23c NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION. 23b DATE THEREOF LOCATION (Stote) City or Town REGISTRAR'S SIGNATURE FUNERAL DIRECTOR REC'D BY REGISTRAR VR A15ME (5) 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral death, 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. COUNTY b. COUNTY after MONTGOMER e by the Pages MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) bon papers. Pag within 72 hours hours SILVER SPRING .≡ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) filled d. STREET ADDRESS e. IS RESIDENCE ON A FARM? TRUSVILLE 01 No X YES: completely 3. NAME OF Middle Last DATE Month DECEASED OF n and complete remove carb 1967 (Type or print) DEATH 20 OUI executed 5. SEX AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 6. CQLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED last birthday) Months WIDOWED DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT TACE (County & State, or foreign country) physician and I certificate be COUNTRY? _INDUSTRY BULLDING RESIDEUT 13. FATHER'S NAME MOTHER'S MAIDEN NAME remova attending parmit. Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? transit permit. 16. SOCIAL SECURITY NO. INFORMANT Address death (Yes, no por funkown) (If yes give war or dates of service) the CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN burial-transit burial, cremat ONSET AND DEATH signed by PART I. DEATH WAS CAUSED BY: ANCREAS E METASTASES DUERGMES. by the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) certificate has been gave rise to Immediate the cr DUE TO cause (a). stating as th underlying cause last. CERTIFICATION PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMEQ? FUNERAL DIRECTOR: After this certificate lifector, page 3 should be detached for use hould be filed with the State Dept. of Health ND N YES 20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part | or Part || of Item 18.) OR CONTRIBUTING (CAUSE OF DEATH (IF EITHER, NOTIFY MEDICALAEXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m While Not While at work at work ATTENDIN be retained to Av9.20 21. I certify that (I) (this hospital) attended the deceased from APRIL 27, 1954. saw the deceased alive on A 1947, and that death occurred at 2-AM, from the causes and on the date stated above. 22b. DATE SIGNED 22a. SIGNATURE ATTENDING PHYS. M.D. DIRECTOR PHYS. Page 4 may ADDRESS PHYSICIAN'S 22d. director, p should be i NAME (Type) ISRAE BURIAL, CREMATION. 2 DREMOVAL (Specify) REC'D BY REGISTRAR REGISTRAB Charles VR A15 (4) 15M 4-64



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) o. COUNTY Montgomery **b** COUNTY Warren Virginia MARYLAND b. CITY OR TOWN (If autside corporate + mits, CLENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) papers. Pag. Bethesda (rural) 58 days Front Royal d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) .⊑ d STREET ADDRESS e IS RESIDENCI ON A FARM? campletely-filled Naval Hospital Belair Avenue NO IX 3. NAME OF carban Middle DATE Year DECEASED Nellie B. ELESA 24 August 67 (Type or print) DEATH S. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS remave lost birthdoy) Months Hours Female and in any Cauc DIVORCED Jan. 3, 1895 WIDOWED 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) **INDUSTRY** COUNTRY? attending physician permit. Then please N/A Clarke County, Virginia USA 13. FATHER 5 NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar removal, James William Bell Lola Mae Bell 15 WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16 SOCIAL SECURITY NO 17. INFORMANT Germantown Address Maryland Not avail ICDR L. A. Jones, MC USN R.D.1. Box 178A 18. CAUSE OF DEATH (Enter only one cause per fine for (o), (b), and (c).) INTERVAL BETWEEN signed by the burnal-transit PART I DEATH WAS CAUSED BY Acute Myocerdio Infarct ONSET AND DEATH IMMEDIATE CAUSE (6) be retained by the hospital ar attending physician. Disease Houi DUE TO Arteriosclerotic Hypertensive Cardiovascular Conditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse be detached far use as the State Dept. af Health priar ta IO FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) PERFORMED?
YES NO ATTENDING PHYSICIAN: 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter notuse of injury in Port 1 or Port 11 of ilem 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Day, Yeor 20d INJURY OCCURRED (City or fown) (County) (Stote) Hour a.m. foctory, street, office bldg., etc.) Not While of work 2) I certify that (IX(this haspital) attended the deceased from June 27 19 67, to Aug. 24, 1967, that \$\) (we) last saw the deceased alive an August 24 19 67, and that death occurred at 215P M, fram causes and on the date stated above. 22o. SIGNATURE 22b. DATE SIGNED Aug. 25, 1967 X director, page 3 shauld be filed v M.D. DIRECTOR PHYS. 22d ADDRESS 10 HOSPITAL Page 4 may | 22c PHYSICIAN'S L. W. RAYMOND M.D. NAME (Type) Naval Hospital, Bethesda, Md. 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23d. LOCATION (City or Yown) ({ounty} (Stote) 1967 Greenhill Cemetery Berryville, Virginia Warner E. Pumphrey Funeral Home Georgia Silver Spring, Md. DATE

MARYLAND STATE DEPARTMENT OF HEALTH

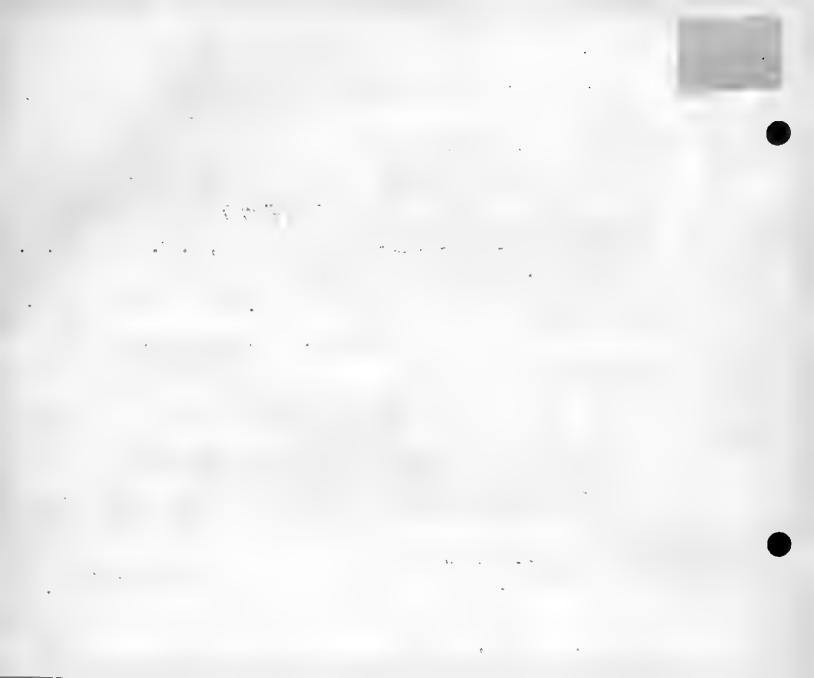
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11174 11173 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased fixed, if institution: Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY The law requires that the death certificate be executed within 24 hours often Il outside corporate limits c LENGTH OF STAY IN 16 c. CITY OR TOWN (It outside corporate limits, write RURAL and give newest town) Write RURAL (If not in hospital, give street address) d STREET ADDRESS a NAME OF HOSPITAL OR INSTITUTION papers ON A FARM? filled NAME OF Middle DATE Year campletely DECEASED OF DEATH (Type or print) AGE (In years IF UNDE SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH Months Dovs Haurs WIDOWED DIVORCED and 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired COUNTRY? physician c INDUSTRY Housewile 13. FATHER'S NAM remava 16 SOCIAL SECURITY NO 17. INFORMAN (Yes, no, or unknown) (If yes give war or dates of service) Б INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a) /(b) and (c)/ signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove (b) rise to immediate couse (a). DUE TO stoting the underlying couse has been the WAS ALTOPSY PERFORMED? PART II OTHER SIGNERCANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) YES [OR ATTENDING PHYSICIAN: certificate 200 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part II of item 18) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Day, Year Hour om. factory, street_office bida/ etc.) 19 ot work TO FUNERAL DIRECTOR: After 5, 19___, that (1) (we) las 21. I certify that (1) (this bospital) attended the deceased fram and that death occurred at 95% M. from causes and on the date stated obove saw the deceased alive on S 220 SIGNATURE 22b DATE SIGNED DIRECTOR director, page 3 shauld be filed v PHYS. 22d. ADDRESS 22c. PHYSICIAN S O HOSPITAL NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town), 230 BUR AL, CREMAT ON, (County) (Stote) REMOVAL (Specific) DC 250 REC D BY REGISTRAR REGISTRAR'S SIGNATURE VR A15 (4)



11-	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MAKYLAND 21201	75
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
HEALTH DEPT.	PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before the country of the coun	
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delay I and 3 f t3 Pag	b (ITY OR TOWN (1 outside carporate limits c LENGTH OF STAY IN 1b c (ITY OR TOWN (1 outside carporate imits, write RURAL and give neores) town)	ist town)
7y delay 2, and 3 PM3 Pa partment	(abin John Capin John	e S RESIDENCE
	d NAME OF HOSPITAL OR INSTITUTION (finat in haspita, give street address) 7905 Woodrow Place 7905 Woodrow Place	ON A FARM?
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the state of the s	rise to immediate cause (a), Stating the underlying cause DUE TO	
retrificate should writing the word rwarded to the Classed as a burial-tre sed as a burial-tre vol, and in ony ev	lost. (c)	O HATCHITODEN
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TO DEPUTY MEDICAL E necessary, please exect the funeral director. Po 5 may be retained for 0 FINERAL DIRECTOR: Health pr or to buriol,	NAME Type) Address (Street city, lown, or countyBetnesda,	
5 # # 6 T	23d BURIAL (REMATION, BURIAL (Specify) 8-31-67 Parklawn Cemetery Rockville, Mary)	and
	ADDRESS 1250 REGISTRAR 256 REGISTRAR 256 REGISTRAR 2 SONAT	URF
VR A 15ME (5) (5)	24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland 250. REGISTRAR 25 S GNAT ROBERT A. PUMPHREY, Bethesda, Maryland 250. REGISTRAR 3 S GNAT ROBERT A.	udge



	Item 18 Film 393 MARYLAND STATE DEPARTMENT OF HEALTH	
	10-5-67 ams Division of VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	176
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
HEALTH DEPT	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence a COUNTY PRODUCT OF STATE b. COUNTY PRODUCT OF STATE COUNTY PRODUCT PRODUCT OF STATE COU	
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ny dela 2, and 3 PM3. P	b CNY OR TOWN (If autside carparate limits, write RURAL and give nearest fawn) Takoma Park c. LENGTH OF STAY IN 16 C CITY OR TOWN (I autside carparate mits, write RURAL and give limits) Takoma Park	tearest tawn)
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d within 24 haurs after death. If on pencil in Item 18. Give Pages 1, Examiner's Office along with farm File pages 1 and 2 with The State De 2 hours after death	3 NAME OF Frst Middle Last 4 DATE Manth	Day Year
after death. 3. Give Page along with free Math	OF (Type or print) Richard Mark Fann DEATH August	18 19 67
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thaulc the (the (unai-t	Conditions, if ony, which gave) (b) intracranial hemorrhage	
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NL EXA xecute . Page far yav and . Page of, cremal, cremal, cremal .	21 I certify that I taak charge of the remains described above, held an Autopsy , Inspection , Inquiry ,	and in my apiniar
₩ X , Ψ D 0	death resulted fram: Natural causes 🔲 , Accident 🛴 Suicide 🔲 , Hamicide 🔲 , Undetermined manner 🔲	
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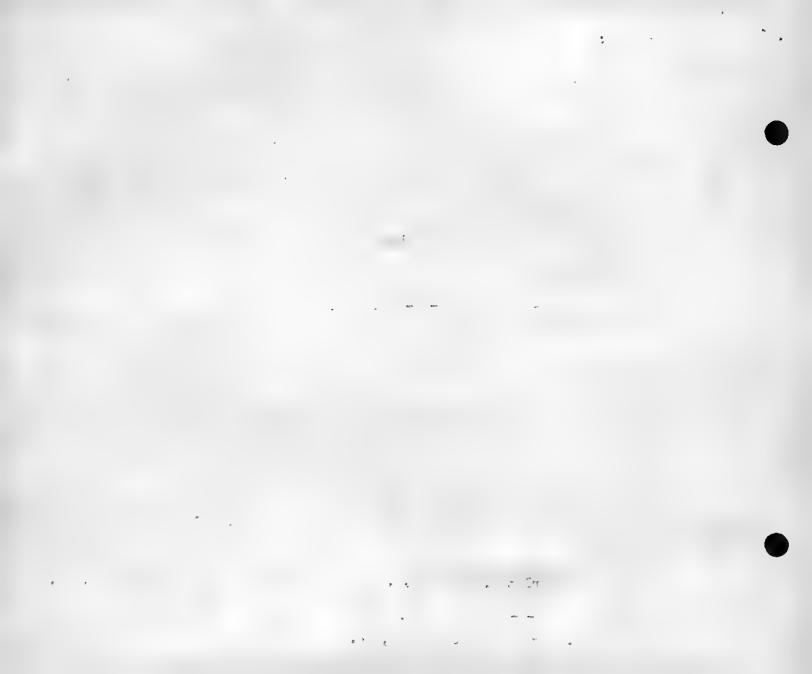
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b. COLINTAL yithin 72 hours after MARYLAND in by the Poges b CITY OR NOWN (If outside corporate/limits write RURAL double of neorest Jown) LENGTH OF STAY IN 16 c. CITY OR TOWN (If, outside corporate limits, write RURA), and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) B. IS RESIDENCE ON A FARM? d STREET ADDRESS filled YES. NO 🔽 NAME OF 4. DATE completely to DECEASED OF DEATH Type or print) 6. COLOR OR RACE AGE (In years last birthdoy) SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED DATE OF BIRTH Hours WIDOWED DIVORCED 100 JSUAL OCCUPATION (Give kind of work done) during most of working the fever if retired) 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT (County & State, or foreign country) INDUSTRY COMNTRY? or removol, and 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S ARMED FORCES? 16. SOCIAL SECURITY NO INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (6) UTEMIA DUE TO Hydronephrosis & pyelonephritis, acute & chronic (b) use to immediate couse (a). DUE TO for use as the t f Health prior to t stoting the underlying couse the hospitol or ottending this certificate hos been Neurogenic bladder due to meningomyelocele PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? NO F 20o ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port 1 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) MED foctory, street, office bldn., etc.) Not While at work TO FUNERAL DIRECTOR: After 21. I certify that (I) (this hospital) attended the deceased from 19 196 / that (1) (we) las be retoined and that death accurred at 100 AM, fram causes and an the date stated above saw the deceased alive on 220 SIGNATURE 22h DATE SIGNED DIRECTOR TO HOSPITAL (Poge 4 moy b 22d. ADDRESS 22c. PHYSICIAN'S Bethesda Wis. Ave. M**W* NAME (Type) J. Tehan director, p 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) ((ounty) (Stole) Cremation Fort Lincoln Bladensburg PG 25b. REGISTEAR'S SEGNATURE Ernest_C ZGartner Gartnersburg Md. 2So. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



	1		DIVISION OF V	MARYLAND STATE ITAL RECORDS, 301 W. F				1	
		11177		CERTIFI	CATE O	F DEATH		E Å	18
		PLACE OF DEATH o. COUNTY		MARYL		USUAL RESIDENCE (W o STATE	there deceased lived, if instit b. (O		ore odmission)
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	3	NAME OF DECEASED (Type or print)	CTFORD.	Middle	Fre	els	4 DATE Mo	1th 000	Year
		SEX 6 CO	M wi	ARRIED NEVER MARRIED DOWED DOWORCED	B DAT	TE OF BIRTH -15-10	9. AGE (In years last birthdoy)	Months Doys	Hours Min.
	dice	USUAL OCCUPATION (Give king most of working life, eve	n if enternall	IOD KIND OF BUSINESS OR INDUSTRY	11.	BIRTHPLACE (County &	State, or foreign country)	12 CHTZEN C COUNTRY	OF WHAT
	13	FATHERS NAME			14.	MOTHER'S MAIDEN N	AME Stright	ist	
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X	L CERTIFICATION	200 ACCIDENT WAS UNDER OR CONTRIBUTING CAUS (IF EITHER, NOTIFY MEDICA	LYING CI SE OF OEATH LEXAMINER)	20b. DESCRIBE HOW INJURY OCC	CURREO (Enter	noture of injury in F	Port I or Port It of item 18.)		
	MEDICAL	20c. TIME OF INJURY Ma Hour o.m. p.m.	nth, Doy, Yeor 19	29d INJURY OCCURRED While Not While of work of work		INJURY (Hame, form treet, office bldg., etc.)	, 20f (City or town)	(County)	(Store)
		saw the decease		attended the deceased f	rom \$ nd that dea	ath occurred at		9/, 196/, 1 and on the do	
		22o. SIGNATURE	Much	Jones	M D P		MED STAFF DIRECTOR PHYS	22b DATE SIG	19/67
1		22c. PHYSICIAN'S NAME (Type)	Stephen	N. JONES		22d ADDRESS		MY	′/ ′
P		BURIAL (REMATION, REMOVAL (Specify) BUTIAL	236, DAT THEREOF 9-2-67	23c NAME OF CEMET Lincoln 1		al	23d. LOCATION (Cety or Suitland,	Maryland	(Stote)
1	2	I. FUNERAL DIRECTOR	- Qo 3	ADDRESS ON-12 ATTE.	livan.	ie DATE	BY REGISTRANGE 25b	REGISTRAR'S SIGNATI	judg



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed-within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH o STATE Maryland b. county Montgomery a COUNTY Montgomery MARYLAND the by the Pages b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest tawn) C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside carparate limits write RURAL and give nearest town) ban papers. Page within 72 haurs o 20 days Olney Olney d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENC ON A FARM? Box 73 Montgomery General Hospital YES TE NO append to NAME OF Middle 4. DATE Last Manth Day Year DECEASED OF DEATH August Elizabeth Finneyfrock 19 (Type or print) Florence IF UNDER 1 YEAR IF UNDER 24 HRS AGE (In years 6 COLOR OR RACE DATE OF BIRTH 7. MARRIED NEVER MARRIED remave last birthday) Months Days Hours 9/27/90 9 White burial, crematian, ar remayal, and in any DIVORCED WIDOWED Female and 10e USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during mast af warking life, even if retired) **INDUSTRY** COUNTRY? physician Home USA Housewife Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Mary Burriss Reuben Hines 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 17 INFORMANT 16. SOCIAL SEGIRITY NO. Address 217-34-1061D Medical Records INTERVAL BETWEEN i8 CAUSE OF DEATH (Enter only one cause por line for (a), (b), and (c).) signed by the c burial-transit p ONSET AND DENTH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) by the haspital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). **DUE TO** stating the underlying cause has been see as the left the prior taken last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) HICATION far use F Health NO certificate 206. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (Caunty) (State) 20c TIME OF INJURY Month, Day Year (City or town) factory, street, affice bldg., etc.) Hour o.m. Not While of work at work 21. I certify that (1) (this haspital afterfied the deceased from Page 4 may be retained and that death accurred at 12 M. fram causes and an the date stated above FUNERAL DIRECTOR: saw the deceased elive an 22a, SIGNATURE STAFF PHYS DIRECTOR M.D r, page be filed 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Charles H. Ligon, Medical Center, Sandy Spring, directar, p NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b. DATE THEREOF 230 BURIAL, CREMATION, (County) (State) 8-7-67 Olney St. John 2 REGISTRADES SIGNATURE 2So. REC'D BY REGISTRAR Laytonsville, Md. 24 FUNERAL DIRECTOR Francis H. Barber VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11180 FOR STATE EALTH DEP PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY o STATE b. COUNTY Page 0 Montgomery

b (ITY OR TOWN (If outs de corporate limits, write RURAL ond give neores) town) MARYLAND Montgomery Maryland c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) and State Departme Bethesda Bethesda e IS RESIDENCE d NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS farm NO YES in Item 18. Give Pages 4853 Cordell Ave. Tiangle Towers Apt 4853 Cordell Ave. be executed within 24 hours after death NAME OF Midde DATE First DECEASED OF (Type or print) DEATH KATHALEEN RISHBACK August 6 COMP RP -ACE 9. AGE (In years IE JINDER 1 YEAR F JNDER 24 HRS SEX 7 MARRIED NEVER MARRIED DATE OF BIRTH White lost birthdoy) Months Sept. 1903 DIVORCED WIDOWED 😓 l analy <u>Female</u> 100. USJAL OCCUPATION (Give k Jat wo k dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 12 CIT ZEN OF WHAT during most of warking life, even if retired) INDUSTRY None within 72 hours ofter N.M. pencil 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Alfred Robls Kate King 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT 5112 Parklawn Ter ef Medical (Yes, no, or unknown) (If yes give wor ar dotes of service) pending 220-46-3756 Barbara F. Edwards- Rockville. No None INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Arteriosclerotic Cardiovascular Disease MMEDIATE (AUSE (a) This cert ficate should writing the ward DUE TO any e Canditians, if any, which gave be farwarded to use to immediate cause (a). = DUE TO stating the underlying couse pub 20 last. WAS AUTOPSY cremation, or removal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(6) PERFORMED? CERTIFICATION the certificate, YES XX NO 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18) 3 shauld should PRIMARY ar CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH MEDICAL 20e PLACE OF INJURY (Hame, form 20f (City or town) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED (County) (Stote) factory, street, affice bldg., etc.) Hour o.m. Nat While may be retained for yaur FUNERAL DIRECTOR: Page ot work please execute of work 21. I certify that I took charge of the remains described above, held on Autopsy XX. Inspection Inquiry and in my apinion Natural causes death resulted from: Accident Suicide 1 Undetermined manner Homicide funeral directar CHIEF MEDICAL EXAMINER X Health priar to ACTUAL 22. DATE SIGNED ASSISTANT MED CAL EXAMINER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street, city, town, or county) NAME (Type) Russell S. Fisher M.D.

| 23b DATE THEREOF | 23c NAME OF CEMETERY OR CREMATORY August 9, 1967 23d LOCATION (City or Town) (County) 23g BURIAL CREMATION. 50 REMOVAL (Specify) Cedar Hill Crematory Cremation Y REGISTRAR S SIGNATURE Sons, Inc. VR A15ME (5) 6M 1/67

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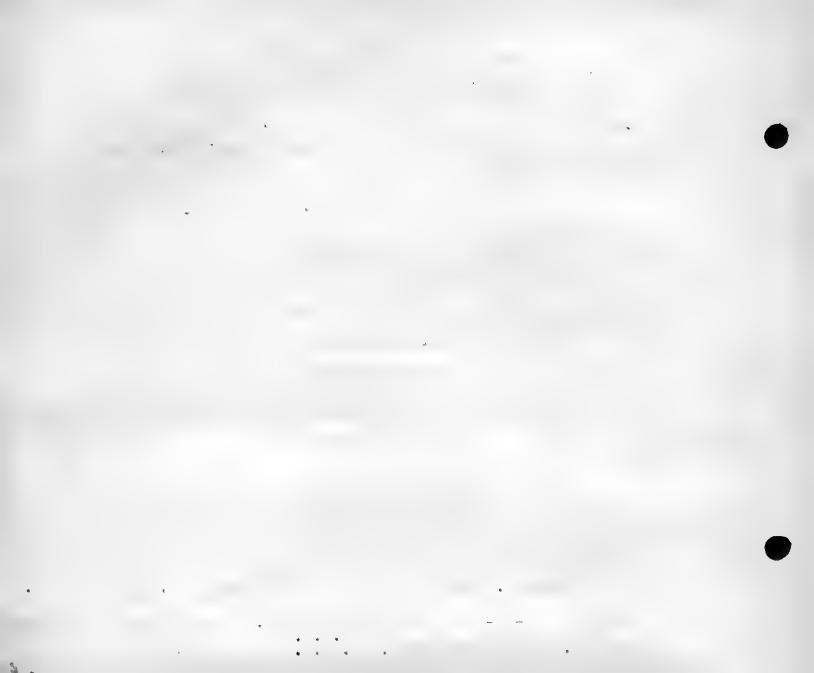
/ 1	It = .s 1 Film 3-3 MARYLAND STATE DEPARTMENT OF HEALTH 1)-11-67 ams Division of VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	111 () MEDICAL EXAMINER'S CERTIFICATE OF DEATH	11181
HEALTH DEEV.	1 PLACE OF DEATH o COUNTY Montgomery Maryland 2 USUAL RESIDENCE (Where deceosed ved, it institut on Re o. STATE Maryland	sidence before admission) Howard
after death If any delay is 8 Give Pages 1, 2, and 3 to along with farm PM3. Page with the State Department of	b CITY OR TOWN (If auts de corporate limits, write RURAL and a ve negrest town) Silver Spring C LENGTH OF STAY IN 1b C CITY OR TOWN (If outs de carporate limits, write RURAL and Silver Spring) DOA Ellicott City	
form PA form P	d NAME OF HOSP TAL OR INSTITUTION (If not in hospital give street address) d. STREET ADDRESS	e IS RESIDENCE ON A FARM? YES NO K
death Page: with fo	3 NAME OF Frst Middle Lost 4 DATE Month OF	Doy Year
after death 18 Give Pages along with far	lost b rthdoy) Mon	NDER 1 YEAR IF UNDER 24 HRS
haurs Item 1 Office Iand2	during most of working life, even if retired) (NDUSTRY	2 C TIZEN OF WHAT COUNTRY?
within 24 Examiner's File pages ?	13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME	USA
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shauld be ne ward "pe to the Chief burial-transif n any event	IS CAUSE OF DEATH (Enter only one couse per me for (d), (b) ond (d) PART I DEATH WAS (AUSED BY Cardioras) iratory failure MAMEDIATE (AUSE (o) Cardioras) iratory failure OUE TO Conditions, if only, which gove (b) due to drowning	NTERVAL BETWEEN ONSET AND DEATH
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rector P anned far IRECTOR	deoth resulted from Natural couses Accident Suicide, Homicide, Undetermined manner	
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TO DI The if the if S mo TO FU Head	230 BURIAL, CREMATION. REMOVAL (Specify) AUC. 13/967 WEST VIEW CEMETERY RADFORD, VIRG.	(Couply) (State)
VR A15ME (5) 6M 1.67	24 FUNERAL DIRECTOR 256 DECISTRAD 256 DECISTRAD 256 DECISTRAD	RS SIGNATURE



		DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
=iM)		CERTIFICATE OF DEATH
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by hand and dear		b. CITY OR TOWN (if outside corporate limits, write RURAL and g vy feerest fown) c. CITY OR TOWN (foutside corporate limits, write RURAL and g vy feerest fown)
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mpleter papers	3.	NAME OF First Middle Last 4. DATE Month Dey Yeer
e S C E	5	(Type or print) Thomas - Edward - Flick DEATH August 26 19 07 SEX 16. COLOR OR RACE 17. MARRIED IN NEVER MARRIED IN B. DATE OF BIRTH 19. AGE (In yeers IF UNDER 1 YEAR IF UNDER 24 HRS.
and carbo	Ĭ.,	Aince / Lest birthday) Months Days Hours Min.
a		USLAL OCCUPATION (Give k nd of work 100 KIND OF BUSINESS OR INDUSTRY: 11 B.RTHPLACE Country & Stele, or foreign country) 12. CITIZEN OF WHAT COUNTRY: ne during most of working life, even if retired)
certifical physician remove any eve		- Me
death ding please	13.	FATHER'S NAME 14. MOTHER'S MAIDEN NAME 5. 1 (1)
e de endi	15.	WAS DECEASED EVER IN U.S. ARMED FORCES? 18. SOCIAL SECURITY NO. 17. INFORMANT Address
at the att	(Ya	is, no, or unkown) (Ifyesgivewerordetesofservice)
by the remit.		18. CAUSE OF DEATH [Enter only one cause par line for (e), (b) and (c), (f) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH
hysical hysica		IMMEDIATE CAUSE (6) MULTIPLE Congenital anomalies
w re po		DUE TO Conditions, if eny, which (b)
he la beer beer beer crei		geva rise to immediate ceuse (a), stating the underlying DUE TO
has has urial		causo lest. (c)
ital circate as the p	CATION	PART II OTHER SIGNIF. CANT CONDITIONS CONTRIBUTING TO DEATH OUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? PERFORMED? YES DE NO
YSIC hosp certif r use prior	TIF C	2De, ACCIDENT WAS UNDERLYING [] 1 2Db. DESCRIBE HOW INJURY OCCURED, (Enter nature of infury in Part I or Part I, of Item 18.)
# 1 年 2 年 2 年 2 年 2 年 2 年 3 年 3 年 3 年 3 年 3	L CERTIF	OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
After hache	MEDICAL	20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm, 4 Hour a.m. 20f. (County) (Stefe)
END taine OR: 7 DE: 0	E	21. I certify that (II) (this hospital) altended the deceased from804.8/24, 196.7, to6.1.18.1.24, 196.7. that (I) (we) assign that (II) (this hospital) altended the deceased from804.8/24, 196.7.
A PATT		21. I certify that (IV (this hospital) aftended the deceased from 34.1.3 [4
Sal		226. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED
AIL FIL h the		22c. PHYSICIAN'S DIRECTOR PHYS 1/4 67
HOSPITALI ath. Page FUNERAL ector, page filed with t		NAME (Type) 50 W. Edmonston Drive, Rockville
O HOSF death. P O FUNI director, be filed	23	BURIAL CREMATION, 23b. PATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Stota)
direction of the first of the f	_	18 58 P. Torsan I lasting 1 120 Lossed - Month. INM
VR A15 (4)	24	FUNERAL DIRECTOR'S SIGNATURE ADDRESS TO ADDRESS TO THE HEADY ADDRESS TO THE HEADY ADDRESS TO THE HEADY ADDRESS TO THE SIGNATURE ADDRESS TO THE HEADY ADDRESS
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2. USUAL RESIDENCE Where deceased lived, if institut on Residence before admission) COURT MARYLAND o. COUNTY o. STATE (If outside corporate limits c CITY OR TOWN (If ourside corporate limits, wrus RURAL and give nearest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS NAME OF First Middle Year DECEASED OF DEATH (Type or print) S. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED AGE (In years IF UNDER 24 HRS remove lost birthday) Dovs and in ony WIDOWED DIVORCED 10b KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done (County & State, or foreign country) 12 CITIZEN OF WHAT during most at working life even if retired) INDUSTRY COUNTRY? ired 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAME or removol. attending poermit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burnal-transit p ONSET AND DEATH Primary hepatoma IMMEDIATE CAUSE (o) DUE TO Hepatic cirrhosis Conditions, if ony, which gove rise to immediate cause (a), DUF TO stoting the underlying couse Page 4 may be retained by the hospitol or attending as the PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPSY this certificate has detached for use on the Dapt. of Health p PERFORMED? Bilateral lobular pneumonia YES 39 NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Stote) (County) foctory, street, office bldg , etc.) Not While at work at work 21. I certify that (1) (this haspital) attended the deceased fram saw the deceased alive an Aug 7, and that death accurred at 6:30A M, from causes and an the date stated above 220 SIGNATURE 22b. DATE SIGNED M.D. PHYS. DIRECTOR PHYS. dimetor, poge should be filed 22d. ADDRESS 22c PHYSICIAN'S FUNERAL NAME (Type 5413 CEDAR LANE. JAMES BETHESDA. 230 BURIAL CREMATION. 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) (County) (Stote) 8-19-67 GATE of HEAVEN CEM. SILVER SPRING 0 2So REC'D BY REGISTRAR VR A15 (4) 25M 1/67 3821 14TH. ST. N.W. DATE AUG



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11183 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased ived, if institution Residence before admission o. COUNTY b. COUNTY 10 Poge MARYLAND Montgonner de oy CLENGTH OF STAY IN 16 c CIY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside comporate puo 2. Months INSTITUTION (If not in hospital, give street address) d STREET ADDRESS 15 RESIDENC ON A FARM? forwarded to the Chief Medical Examiner's Office along with farm in Item 18. Give Poges YES 24 hours after death 3 NAME OF Lost DATE Month Dov Year DECEASED **OF** eir c57 196 (Type or print) DEATH DATE OF BIRTH -S SEX 6 COLOR OR RACE AGE (In years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED buthdoy) lost Months WIDOWED D VORCED and in ony event within 72 hours ofter death poges lond2 10o USUA, OCCUPATION (Give kind of work done 10h K ND OF BUSINESS OR 11 BIRTHPLACE (Stote or fore an country) 12 CT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? 1017013 Housewife Home 13 FATHER'S NAME This certificate should be executed within 14. MOTHER'S MAIDEN NAME in pencil Andrew Ambuhl Caroline Wicke permit. File 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT 901 Langley Dr. (Yes, no, or unknown) (If yes give wor or dotes of service) pending Charles F. Pratt (Son)Sil.Spg., Md.20901 No 577-56-2588 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-transit Coronary Insufficency - Acrote IMMEDIATE CAUSE (o) writing the ward DUE TO Coronary Thron-bosis Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse D. Cardio Vasculas Disease 9 nsed or removal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1(a) WAS AUTOPS: PERFORMED? please execute the certificate, YES NO pe should be 200 EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) 3 should CERT PR MARY Or CONTR BUTING CAUSE OF DEATH cremotion, 8 20e PLACE OF INJURY (Home form 20c T ME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (City or town) (County) (Stote) Yaur ноиг о.т. Not While foctory, street, office bldg, etc.) FUNERAL DIRECTOR: Poge of work of work 21. 1 certify that I took charge of the remains described above, held an Autapsy Inspection and in my apinion Natural causes Accident death resulted fram Suicide Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior 1 SIG NATURE the funeral O DEPUTY DEPUTY MEDICAL EXAMINER W John G. Ball. may TO FUNE Hearth NAME .Type) Address (Street city town, or county) 23c BURIAL CREMATION 23b DATE THEREOF 23r NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 5 REMOVAL (Specify)
Burial Fort Lincoln Cemetery Bladensburg. Md 24 FUNERAL DIRECTOR RELD BY RECHTRANGED 250 BYETCHERS SOLL VR A15ME (5) Joseph Gawler's Sons, Inc., Wash., D. C. 6M 1/67 DATE



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
~	CERTIFICATE OF DEATH
irs after death Pages I and a	1 PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) Silver Spring 15 days 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY b. COUNTY c. CITY OR TOWN (If outside carporote limits, write RURAL and give nearest town) Takoma Park
within 24 hau	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) Holy Cross Hospital 3. NAME OF DECEASED DO A FARM? TO BE ASTEET ADDRESS ON A FARM? YES NO X OF DECEASED ON OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) ON A FARM? YES NO X OF DECEASED
e be executed on ond completions on ond completions or remove for and in any events	S SEX 6. COLOR OR RACE 7 MARRIED 1 8 DATE OF BIRTH 9 AGE (In years lost brithday) Male White WIDOWED DIVORCED 4/3/89 9 AGE (In years lost brithday) Months Days Hours Min. L 26
equires that the death certificate be executed within 24 haurs after death physician. signed by the attending physicion and completely filled in by the funeral burial-transit permit. Then please remove torban pepers. Pages 1 and 2 burial, cremation, or removol, and in any event within 72 hours after death.	John Frank Swas Decrased Ever In U.S. Armed Forces? (Yes, no, or unknown) (If yes give wor or doles of service) No Not Available MRS. J.H. FRANK 7719—EASTERN AVENUE
law requires that the death certificate be executed within 24 haurs after death nding physician. been signed by the attending physician and completely filled in by the funeral state burial-transit permit. Then please remove torban gepers. Pages I and in to burial, cremation, or removal, and in any event within 72 hours after death	18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Canditions, if any, which gave rise to immediate couse (o), stating the underlying cause last. (c) INTERVAL BETWEEN PRODUCT OF COLOR (o), and (c).) Conditions, if any, which gave rise to immediate couse (o), stating the underlying cause (c)
YSICIAN: The lospitol or other certificole hos bed for use os otto of Health pri	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS ALTOPSY PERFORMED? YES NO 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Poge 4 may be retained by the hospital or attending physician. (O FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-transhould be filled with the State Dept. of Health priar to burial, creating the state of the state	20c TIME OF NJJRY Manth, Doy, Year Hour o.m. p.m. 19
TO HOSPITA Poge 4 moy Poge 1 pure 10 FUNERAL director, poge 5 should be f	NAME (Type) Aaron H. Traum, M.D. 8237 Georgia and - Silver Spring Wayland. 230 Execut, CREMATION: 1019 1019 1019 1019 1019 1019 1019 1019

c FEIC. 4

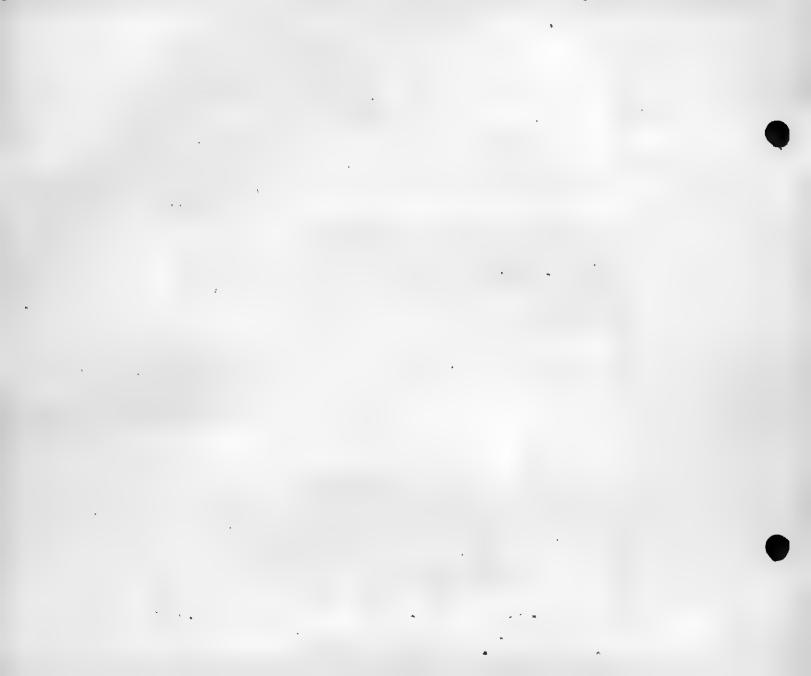
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 111186 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) and campletely filled in by the funeral PLACE OF DEATH Montgomery b. COUNTY Montgomery MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, Swinte RURAL and give nearest town) Silver Spring uears d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ON A FARM? 511 Pershing Drive Pershina Drive YES | NO D *it II NAME OF Middle 4 DATE First Lost Month Year DECEASED **OF** Roulianne (Type or print) Maria Gaanon DEATH August 500 S SEX DATE OF BIRTH 9. AGE (In years 6. COLOR OR RACE IF UNDER 1 YEAR 7 MARRIED **NEVER MARRIED** remove Months birthdoy) Doys Hours white July 8, 1883 temale WIDOWED DIVORCED 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT piease duling most of working life, even if retired) INDUSTRY COUNTRY? Own home Canada 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remayal, Henri Boulianne Celina Tramley WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 511 Pershing Drive Silver Spring, Man (Yes, no, or unknown) (If yes give wor or dates of service) No 219-46-7061 Godbous crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit burial, cremati ONSET AND DEATH PART I. DEATH WAS CAUSED BY: arcinomalosis signed by IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse ₽ has been priorto last. (c) WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) Gagnon, tached for use Dept. af Health g CERTIFICATION use YES | NO 🔀 certificate haspital or 205, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (Stote) 20c, TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) TO FUNERAL DIRECTOR: After this Hour o.m. Not While foctory, street, office bldg., etc.) of work at work 19.67, that (I) (we) last 2). I certify that (I) (this haspital) attended the deceased from to August be retained 400 P.M. fram causes and an the date stated above 1967, and that death accurred at August saw the deceased glive on. 22b. DATE SIGNED 220. SIGNATURE X DIRECTOR PHYS. M.D. 22d ADDRESS 22c PHYSICIAN'S NAME (Type) 4301 23r. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) 23o. BURIAL, CREMATION, 23b. DATE THEREOF R REMOVAL (Specify) Parklawn Cemetery Rockville, Maryland 25b REGISTRAR'S SIGNATURE 2So REC'D BY REGISTRAR Georgia Avenue Milane VR A15 (4) 1967 DAAUG 20 M 1/66 Pumphrey.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Item #9 Film #G392 9 18 67 ph & Item #8 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence pefore admission o. COUNTY COUNTY MARYLAND E LENGTH OF STAY IN 16 b. CITY OR TOWN write RURAL and give nearest town IS RESIDENCE ON A FARM? YES NO X corbon NAME OF Middle DATE Year DECEASED OF DEATH OLORES Type or print) IF UNDER 1 YEAR UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED rémove rthdoy) Months Doys Hours WIDOWFD DIVORCED TOb. KIND OF BUSINESS OR OCCUPATION (Give kind of work done 11 BIRTHPLACE (County & State or foreign country) 32 CITIZEN OF WHAT please INDUSTRY HIME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremotian, or removal, ISABELLE 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT (Yes, no_on_nknown) (if yes give was or dates of service DRYBURGH, TAKORIA PARK MD signed by the a buriof-transit pe 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).
PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH .IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove (b) rise to immediate couse (o), DUE TO stoting the underlying couse lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO X 2Do ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc TIME OF INJURY Month, Doy, Year 2Dd INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 2Df (City or town) (County) (State) Hour o.m. foctory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After 21. I certify that (I) (this haspital) attended the deceased fram_ 19.6.), that (1) (we) last O HOSPITAL OR AFTEND Page 4 may be retained director, page 3 should shauld be filed with the 19 67, and that death accurred at saw the deceased alive an M, fram causes and an the date stated abave 220 SIGNATURE 22b. DATE SIGNED DIRECTOR M.D. 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Sond 7701 23o. BUR AL CREMATION REGISTRAR'S SIGNATURE 24 FUNERAL REC D BY REGISTRAR VR A15 (4) 25M 1/67



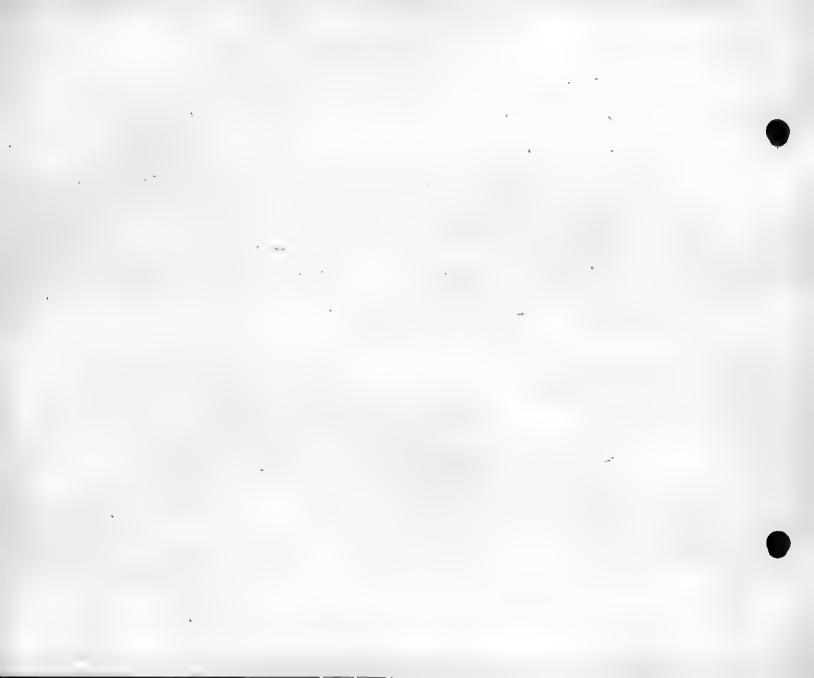
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND Photo Park CERTIFICATE OF DEATH death. and 2 death. PLACE OF DEATH a. COUNTY USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) b. COUNTY 24 hours after MONTGOMERY MONIGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) Ξ. SPRINGS filled d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS a. IS RESIDENCE ON A FARM? eyent, within NO A completely f death certificate be executed within NAME OF Middle Month Year DECEASED (Type or print) AS DEATH 19 6 remove SEX 6. COLOR OR RACE AGE (in years | IF UNDER 1 YEAR | IF UNDER 24 HRS | Jast birthday) | Months | Days | Hours | Min. NEVER MARRIED 007 any WIDOWED DIVORCED physician a and in 10a. USUAL OCCUPATION (Give kind of workdone) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT (County & State, or foreign country) during most of working life, even if retired) INDUSTRY Safemay ood Stores !! Retired AMERI 100 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removai attending l srmit. Then William H. Gaskins yaskins 15. WAS DECEASED EVER IN U.S. ARMED FORCES? ed by the attend transit permit. , cremation, or re 16. SOCIAL SECURITY NO. East Wayne Address (Yes, no, or unkown) (If yes give war or dates of service) Eleanor Yask no 18. CAUSE DF DEATH (Enter only one cause per line for (a), (b), and (c).] After this certificate has been signed by the doe detached for use as the burial-transit is state Dept. of Health prior to burial, cremat INTERVAL BETWEEN ONSET AND PEATH 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician. 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. (c) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? for use f Health YES NO Z 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20e. PLACE OF INJURY (Home, farm, I 2Dd. INJURY OCCURRED 20f. (City or town) (State) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work TO FUNERAL DIRECTOR: A director, page 3 should should be filed with the 21. I certify that (I) (this hospital)/attended the deceased from GOOM, from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22b. DATE SIGNED ATTENDING PHYS. STAFF PHYS. M.D. DIRECTOR PHYSICIAN'S 22d. ADDRESS NAME (Type) 23a. BURIAL, CREMATION, DATE THEREOF 23b. 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) VR A15 (4) Georgia Hvenne DATE 1/65



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death Yeard Y PLACE OF DEATH physician and completely filled in by the funeral 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b COUNTY ONTGOMER MARYLAND b CITY OR TOWN (If outside corporate I mits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ATON OF HOSPITAL OR, INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? NO D 3. NAME OF Middle DATE Doy DECEASED OF (Type or print) JUGUST 1967 DEATH SEX 2 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH 9. AGE (In years IF JNDER 1 YEAR IF JNDER 24 HRS **NEVER MARRIED** pleose remove WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of work ng life, even if retired INDUSTRY-U251A -007 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME NENDER UNENOW 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT (Yes no, or upknown) (If yes give wor or dates of service) LEFFICE NOWN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY CORONARY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse be retained by the hospital or ottending TO FUNERAL DIRECTOR: After this certificate has been the last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? DSTATIC PERTROPHY NO Į. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS JNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year (City or town) 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (County) (State) foctory, street, office bldg., etc.) Hour o.m. Not While . 19 67, to 10005/1341967, that (1) (we) last 21. I certify that (1) (this-hespital) attended the deceased from July 137 saw the deceased alive on August 13 19 6 7, and that death accurred at 4-30 cm, from causes and on the date stated above. 220 SIGNATURE 22b. DATE SIGNED 167 M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) director, BURIAL (REMATION, REMOVAL (Specify) 23c. NAME OF CEMETERY OR CREMATORY 23b_ DATE THEREOF 23d DOCATION (City or Town) (County) (Stote) 24. FUNERAL DIRECTOR REGISTRAR'S SIGNATUR VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11190 MEDICAL EXAMINER'S CERTIFICATE OF DEATH I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY. Montgomeryo STATE b. COUNTY 0 State Deportment of MARYLAND deloy b CITY OR TOWN (f outside carparate in ts, limits, write RURAL and give nearest tawn) c. ENGTH OF STAY IN 1b. puo Gaithersburg d NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS B IS RES DENCE ON A FARM? Examiner's Office olong With Merm 16 Long Drs NO [X] YES This certificate should be executed within 24 hours ofter death 3 NAME OF M-ddle Last Month Doy Year DECEASED 0F with the AU9051 pending in pencil in Item 18 Give (Type or pnnt) DEATH 19 61 SEX DATE OF BIRTH F UNDER IF UNDER 24 HRS 7 MARR ED NEVER MARR ED AGE (n years 19273 glast birthday) Months Hauts cremation, or removal, and in any event within 72 hours ofter death WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working fe, even if retired) 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Ver 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCA, SECURITY NO. 17 INFORMANT Dogwood (Yes, na, or unknown) (If yes give war, or dates of service the Chief Medica Madaline 220-28-5081 Gai thersburg SONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) burial-fransit PART I. DEATH WAS CAUSED BY: Gun Shot Wound of neck and Chest IMMEDIATE (AUSE (a) writing the ward DUE TO Canditions, if any, which gave (6) rise to immediate cause (a), forworded to DUF TO stating the underlying couse 0 19 WAS AUTOPS PERFORMED? YES X NO 3 should be used PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAU DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO [the certificate. þe 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) PRIMARY OF CONTRIBUTING CAUSE OF DEATH should I EXAMINER: files. MEDICAL 20e PLACE OF INJURY (Home, form 20c TIME OF N.JRY Manth Day, Year (County) Nat While Hour om factory street office bldg , etc.) FUNERAL DIRECTOR: Poge 1967 Rural. Gaithersburg Mont-Md 21500 at work Home 4 orel Inspection X. 21 I certify that I took charge of the remains described above, held on Autopsy 121, Inquiry XI, ond in my opinion deoth resulted from Undetermined monner Noturol couses Accident Surcide Homicide X the funeral director may be retained 5 may be retaine TO FUNERAL DIRE Heofth prior to b CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAM NER SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME (Type) Address (Street city, town or county) NAME OF CEMETERY OR CREMATORY 23g BURIAL CREMATION DATE THEREOF 23d LOCATION (City or Towns REMOVAL (Specify) 24 FUNERAL DIRECTOR VR A15ME (5) > 6M 1 '67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11190 CERTIFICATE OF DEATH 11797 PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before parmission) a. COUNTY o. STATE Mary Land b. COUNTY Montgomery Montgomery MARYLAND papers. Pages, In 72 hours after c. CITY OR TOWN (If outside corporate l'mits, write RURAL and give neasest town) b CITY OR TOWN (If outside corporate imits, CLENGTH OF STAY IN 1b. OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours aft write RURAL and give nearest town) Bethesda Bethesda vears d, NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Weymouth Street 10507 10507 Weymouth Street YES NO SC 3. NAME OF First 4. DATE Month Lost Dov Year carba DECEASED ELIZABETH 17, 19 67 GOOKEN Aug. (Type or pnnt) DEATH S SEX IF UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years IF UNDER 24 HRS lost birthday) Dovs White Dec. 23,1892 Female WIDOWED DIVORCED and 10b. KIND OF BUSINESS OR 100 USUA: OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working ite, even if retired) attending physician of manual of the state o INDUSTRY COUNTRY? Lowell. Mass. U. S. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal. John Tracy Margaret Curley 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Husband 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) Same as Item 2. 215-48-3826 George A. Booken burial, crematian, 18 CAUSE OF DEATH (Enter only one couse per line for (g), (b), and (c) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH GRYE Rios de Rosi IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital ar attending physician EMPHYSEMA DUF TO BO ASTHOYA Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse are detached for use as the State Dept. of Health prior to MONTH 9 POOT. lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? YES [NO 200 ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Doy, Year (City or town) (County) (Stote) Hour o.m. factory, street, office bldg, etc.) Not While attended the deceased fram July 1954, to July 17, 1967, that (1) (we) last 4 17 1967, and that death occurred at 200 M, fram causes and an the date stated above 21 I certify that (1) (this haspital) attended the deceased from TO FUNERAL DIRECTOR: saw the deceased alive an. 22c. SIGNATURE 22b BATE LIGNED eran arm **ATTENDING** M.D. PHYS DIRECTOR director, page should be filed 22d. ADDRESS 22c PHYSICIAN S NAME (Type) 10101 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23d LOCATION (City or Town) (County) (Stote) Burlal-transit St. Patricks Cemetery. 8-21-67 Lowell. Mass. **ADDRESS** 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Maryland VR A15 (4) 25M 1/67 PUMPHREY. Bethesda.



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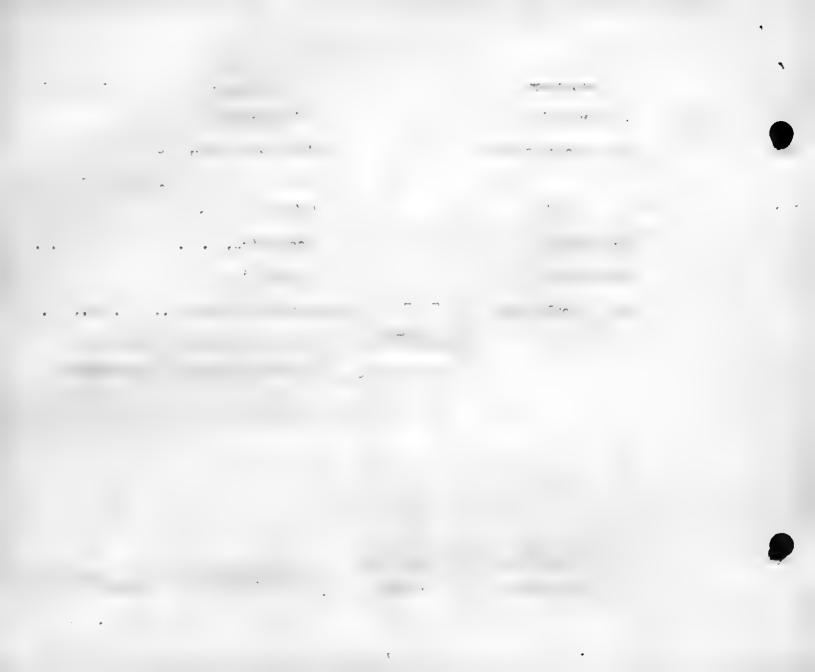
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH ion papers. Poges 1 and within 72 hours after death 24 hours ofter deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution_Residence before admission) > o. COUNTY **b** COUNTY MARYLAND Poges b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest fown) .⊆ d. STREET ADDRESS IS RESIDENCE ON A FARM? filled YES NO 🖂 requires that the death certificate be executed within pon NAME OF 4. DATE Month Year DECEASED OF DEATH (Type or print) and in also event IF UNDER 1 YEAR AGE (In years IF UNDER 24 HRS 7. MARRIED DATE OF BIRTH birthdoy) WIDOWED DIVORCED 106 KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, ps/foreign country) 12 CITIZEN OF WHAT physician a ien pleose during most of working life, even if retured) 13 FATHER'S NAME signed by the attending physi buriol-transit permit. Then pl buriol, cremotian, or remavol, 14. MOTHER'S MAIDEN NAM nawrence 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT 61 Ko mal (Yes, no, ar unknown) (If we give war or dates of service 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if any, which gove 10 rise to immediate couse (a), DUE TO stoting the underlying couse os the priar to TO FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) be detached far use State Dept. of Health NO 200 ACCIDENT WAS UNDERLYING [3] 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. (County) (Stote) Not While foctory, street, office bldg., etc.) of work ot work 21. I certify that (1) (this haspital) attended the deceased fram one, le to Oug, 13 1961, that (1) (we) last director, page 3 should should be filed with the ave. 19 61, and that death accurred at 8 45 AM, from causes and on the date stated above 15 saw the deceased alive an. 22o. SIGNATURE 22b. DATE SIGNED MED DIRECTOR 13 M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S McCormick NAME (Type) Robert 11161 New Hampshire ave Silver SpringsMd 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION, (County) (Stote) REMOVAL (Specify) Wheaton Montgomery Gate of Heaven Cemetery Md. Aug. 16, 1967 Burial 2So REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 AUG 16 Hyattsville, Md. F. Gasch's Sons



MAKYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11194 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 haurs after death and completely filled in by the funeral semone carbon papers. Pages I and in ony event, within 72 hours offer death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institut on. Residence befare admission) n. COUNTY o. STATE b. COUNTY Montgomery Maryland Montgomery MARYLAND b. CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 16 (CITY OR TOWN (If autside carparate limits, write RURAL and give negrest tawn) Rockville Damascus d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? Potomac Valley Nursing Home YES NO X 25900 Ridge Rd 3 NAME OF 4 DATE Day Year DECEASED Lillie M. Hager (Type or print) 19 67 DEATH Aug. , YEAR 6. COLOR OR RACE 8. DATE OF BIRTH IF UNDER IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED 9. AGE (In years last birthday) Months Hours Doys ond in ony White 75 Pemale WIDOWED DIVORCED 24.1887 10g, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT r this certificate has been signed by the attending physicion detached for use as the bunal-transit permit. Then please during most of warking life, even if retired) INDUSTRY COUNTRY? Own home Montgomery Co., 13. FATHER'S NAME removol, Edward Thompson Margaret Purdum IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknawn) (If yes give wor or dates of service 6 215-46-3723 Mrs George G. Matthews, Falls Church cremotion. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Advanced Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (a) Poge 4 may be retoined by the haspital ar ottending physician. with Large Fusirorm Aaneurysm . Hypertension and ? Conditions, if any which gove Terminal Cardiac Decompensation. nse ta immediate cause (a), DUE TO stating the underlying cause ed for use os the of Health prior to last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO X 20o ACCIDENT WAS UNDERLYING [7] 205. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER! be detoched State Dept. o 20c. TIME OF INJURY Month, Doy, Year 20d. INIURY OCCURRED 20e PLACE OF INJURY (Home, farm, (City or town) (County) (State) Haur a.m factory, street, office bldg., etc.) Not While ATTENDING at wark O FUNERAL DIRECTOR: After at wark 2). I certify that (1) (this haspital) attended the deceased fram Feb. 14, 19679 ta August 12, 1967, that (1) (329 last 3 shauld b saw the deceased alive an August 12. 19 67, and that death accurred at 10:45M, Alim causes and an the date stated above. 22a SIGNATURE 22b. DATE SIGNED **ATTENDING** STAFF PHYS. 8/12/67 director, page 3 should be filed v PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN S M. McKendree Boyer, 9701 Church Street NAME (Type) Damascus. Maryland. 23a BURIAL CREMATION 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State) REMOVAL (Specify) Aug. 15.1967 Damascus Meth. Damascus, Md. 24 FUNERAL DIRECTOR ADDRESS 25g. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4) Molesworth. Damascus. Md. 1967 20 M 1/66 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH THEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) b COUNTY Montgomery o COUNTY o STATE Montgomery MARYLAND b CITY OR TOWN (floutside corporate limits CLENGTH OF STAY IN TH c CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) P.M3 SILVER Spring Silver Spring d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARMA alang with farm the State De 8484 16th Street, #907 Holy Cross Hospital This certificate should be executed within 24 hours after death 4 DATE NAME OF Middle Month First Lost Day DECEASED LEE POE HART 19 67 August (Type or print) DEATH 8 DATE OF BIRTH IF UNDER 24 HRS 5 SEX AGE (In years IF UNDER 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 68 birthday) Months Hours Male White 1/8/1899 WIDOWED DIVOR CED 11 BIRTHPLACE (State or foreign country) 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY Washington, D. C. U.S. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME event within 72 haurs George Hart Mamie Pie (Yes, no, or unknown) (If yes give were or gates of service) 577-09-8176 (Wife) 17 INFORMANT Address Hazel Hart 8484 16th St., Sil. Sp., Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per ling ONSET AND DEATH PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause PART II OTHER SIGN FICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS ALTOPS PERFORMED? 20a EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of mury in Part 1 or Part 1 of item 18.) PRIMARY ar CONTRIBUTING CAUSE OF DEATH MEDICAL (City or town) 20c. TIME OF INJURY Month, Day, Year 20d N. RY OCCURRED 20e PLACE OF NJURY (Home, farm (County) factory, street, affice bldg, etc.) Not While of work 21 I certify that I taak charge of the remains described above, held on Autapsy Inspection X Inquiry 5 and in my apinian Natural causes Suicide Undetermined manner CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE NAME (Type) 23c NAME OF CENTERY OR CREMATORY 23o BURIAL CREMATION 23b. DATE THEREOF REMOVAL (Specify) Glenwood Cemetery 8-4-67 Washington, 2Sb. REGISTRAR'S SIGNATURE 25a REC D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15ME (5) PUMPHREY, Bethesda, Maryland 1967 DATIAU G 6M 1767



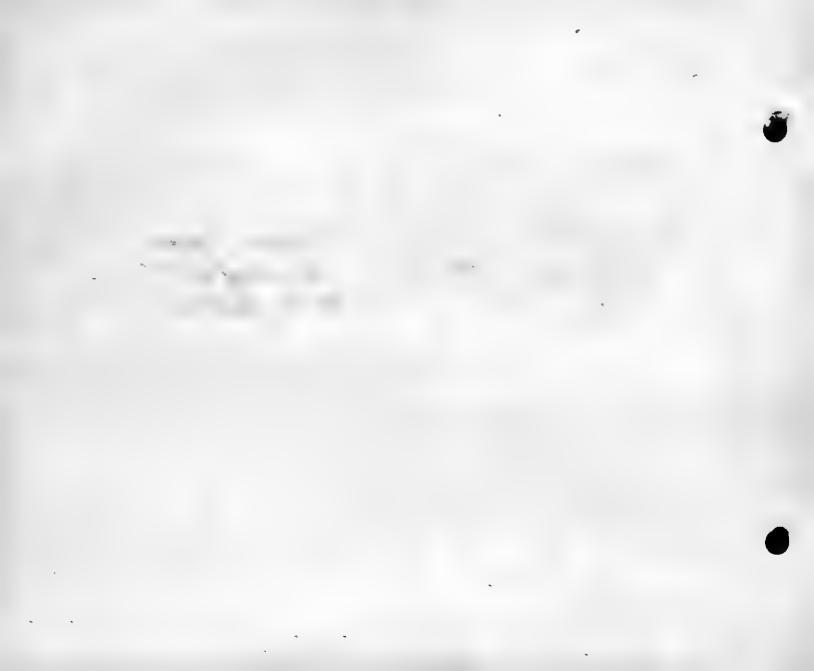
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11196 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH ease remove carban papers. Pages V and and in the second in the second and in the second second in the second seco o. COUNTY b. COUNTY MARYLAND DISTRICT OF COLUMBIA MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs WASHINGTON ETHESDA d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? BURBAN YES. NO 🔀 Middle 3. NAME OF DATE Year DECEASED 25 19 (Type or print) ENNETH DEATH TUGUST IF JNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED 8. DATE OF BIRTH 9. AGE (In years S. SEX NEVER MARRIED lost birthdoy) Months Dovs Hours DIVORCED WIDOWED MHITE 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? JENN. SCHOOL TEACHER WISTERT SC 400 LS 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME ar remaval, HAWKINS attending poermit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN' 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service KINS-SEE ITEM NO crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). signed by the burial-transit PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) be retained by the haspital or attending physician. DUE TO burial, Conditions, if any, which gave rise to immediate cause (a), DUE 10 stoting the underlying couse priar ta lost. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 105 NO certificate 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20r. TIME OF INJURY Month, Day, Year After this Hour o.m. foctory, street, office bldg., etc.) Not While ot wark at work 21. 1 certify that (1) (this haspital) attended the deceased fram 19 6 ! that (1) (we) los and that death accurred at SOCAM, fram causes and an the date stated above saw the deceased alive on O FUNERAL DIRECTOR: 220 SIGNATURE **WATE SIGNED** 22b. M D DIRECTOR PHYS. PHYS. director, page shautd be filed 22d. ADDRESS 22c. PHYSICIANS Wisc. Wash DC R. Shapiro NAME (Type) Dr Jay Ave. 230 BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23h DATE THEREOF (County) REMOVAL (Specify) Removal Cem Baltimore Baltimore Nat 1 1967 world



1/	H	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE		Them 2 255 1362 P/25 167 Mc	198
HEALTH DEPT.	1	PLACE OF DEATH O. COUNTY MONTGOMERY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, if institution Residence of STATE No. 2 STATE NO. COUNTY)	e before odm ssion)
ooth. If any deloy oges 1, 2, and 3 ith form PM3. Pa		b CITY OR IDWN (If autside carparate limits, write RURAL and give georest town) C. LENGTH OF STAY IN 16 C. CITY OR TOWN (If outside corporate limits, write RURAL and give georest town) ASSET Parks, I. L. L. Sphilosophia (Industry) (Indust	Market (awn)
oges 1, 2 in form in form	L	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Luashington Sanitarum & Hospital 85/05/Sptyngarker & Divertor NAME OF Lost Under Hospital Lost Under Hospita	ON A FARM? ON A FARM? NO Year
offer de long w	5	DECEASED (Type of point) Margaret NMN Heberton DEATH Avaist SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 18 DATE OF BIRTH 9 AGE (In years IF UNDER)	70101
24 hours in Item 11 r's Office es Tond 2	1De dur	b. USUAL OCCUPATION (Give kind of work done Industry) 10b. KIND OF BUSINESS OR II. BIRTHPLACE (State or foreign country) 11c. CTI. COU	ZEN OF WHAT INTRY?
l within 24 hours on pencil in Item 18 Exominer's Office of File pages Tond 2 in the factor ofter deother a pours ofter deother some start of the pencil in the factor of the factor of the pencil in the factor of		FATHER'S NAME GEORGE Millar WAS DECEASED PAR IN U.S ARMED FORCES? 16. SOCIAL SECUR TY NO 17. INFORMANT Address	
executed Inding' in Medical E I permit F		es, no, or unknown) (If yes give wor or dates of service) 027-09-8508 Hospital RECORDS 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)	INTERVAL BETWEEN
should be executed as word "panding" in the Chief Medical E burial-tronsit permit F		PART I. DEATH WAS CAUSED BY IMMEDIATE (AUSE (o) Acute, bilateral, pneumonitis; DUE TO PART I. DEATH WAS CAUSED BY Acute, bilateral, pneumonitis;	ONSET AND DEATH
		Conditions, if ony, which gove rise to immediate couse (0), stoting the underlying couse lost. (b) Anemia: Arterioscleratic heart disease DUE TO (c)	
t: This certificate s rif cote, writing the ld be forworded to cld be used as a b or removal, and in	CATION	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE COND TON GIVEN IN PART 1(0)	PERFORMED? YES 40
INER: Thire certificate should be files. 3 should be should be files.	AL CERTIFICATION	20b. DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Port II or Port II of item 18.) PRIMARY II or CONTRIBUTING II CAUSE OF DEATH	
	., MEDICAL	20c TIME OF INJURY Month, Doy, Year Hour a.m. 20d N.JRY OCCURRED 2De PLACE OF INJURY (Home, farm foctory, street, office bldg., etc.) 2Df (City or town) (Court of twork of work foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town) 2Df (Court of twork foctory, street, office bldg., etc.) 2Df (City or town)	
크 힐 ~ 호였 수		21. I certify that took charge of the remains described above held on Autopsy , Inspection , Inquiry death resulted from Natural causes , Accident Suicide , Homicide , Undetermined manner	and in my apinion]
EPUTY M.C./A Smory, please as funeral director of be retained INERAL DIRECTOR		SIGNATURE SIGNATURE ASSISTANT MED CAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	22. DATE SIGNED
TO DEPUTY necessory, the funera 5 moy be 10 FUNERA Heolth prin	230	NAME (Type) BELDEN K, TEHLULO, Middless Astree Kity Lighted, for county)	(County) (State)
VR A15ME (S)	24	FUNERAL DIRECTOR ADDRESS 250 REC'D BY REG STRAR 256 REG STRAR'S SIG	GNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a COLINTY MARYLAND b CITY OR TOWN (It autside carparate limits. C. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corparate limits, write RURAL and give negrest/town) write RURAL and give nearest lawn NSING d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES 3. NAME OF Day DECEASED (Type or print) DEATH S SEX 6 COLOR OR RACE 9. AGE (In years 7. MARRIED NEVER MARRIED DATE OF BIRTH last birthday) Months WIDOWED DIVORCED 12 CIT ZEN OF WHAT 10g USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR during most of working life, even if retired) DEACCN + 3513 FATHER'S NAME MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMAN 16 SOCIAL SECURITY NO. (Yes, na, ar with nawn) (If yes give war or dates of service) INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. IMMEDIATE (AUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a). DUE TO stating the underlying couse has been 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) YES [NO this certificate 200. ACCIDENT WAS UNDERLYING CONTRIBUTING CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (Stote) 20c. TIME OF INJURY Month, Day, Year (County) factory, street, affice bldg., etc.) Nat While at work 21. 1 certify that (i) (this haspital) attended the deceased from 19.67, that (I) (we) las 19 6 7 ta 19 67, and that death accurred at 43 A M, fram causes and an the date stated above TO FUNERAL DIRECTOR: saw the deceased alive an 22o SIGNATURE 22b. DATE SIGNED ATTENDING PHYS DIRECTOR 22c. PHYSICIAN'S 22d ADDRESS NAME (Type) Gred A. Gill directar, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23a BURIAL, CREMATION Fort Lincoln Prince Georges Co. han ADORUS 4 Ga., Ave. 250 REC'D BY REGISTRAR Juneral Home Silver Spring. l'orts



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 71199 11200 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased yed, if institution Residence before admission) a. COUNT GOMERY

b CITY OR TOWN (If outside carporate limits, write RURAL and give nearest lown) MARYIAND When on arriand MONTGOMERY c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest tawn) LENGTH OF STAY IN TH illed in by the popers. Page hin 72 hours o WhEaton d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RESIDENCE filled Randolph Hills Nursina Home YES 🔲 NO F the death certificate be executed within WITH 3. NAME OF Middle 4. DATE Month Day Year DECEASED OF Mary ď, (Type or point) AUGUSI 1967 DEATH SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH remove Š last birthday) Months Days Haurs ond in ony DIVORCED WIDOWED 1290 ond 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician o during most of working life "even if retired) INDUSTRY Housewite Washington 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME burial, cremation, or removal, ottending phys 17. INFORMANT Augustus Neitzen WAS DECEASED EVER IN U.S. ARMED FORCES 16 SOCIAL SECURITY NO 94th Avenue (Yes, ga, or unknown) (If yes give war at dates of service Seabrook. INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY **burial-transst** ONSET AND DEATH neumon IMMEDIATE CAUSE (6) ottending physicion. DUE TO signed 1 Canditians, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse os the prior to PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? Cerebral ARTERIOSTIEROSIS Genera PHYSICIAN: 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) at home detoched BhaIN going from hed MEDICAL 20c TIME OF INJURY Mapth Dov. Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) ({aunty) (State) Nat While Haur a m factory, street, affice bldg , etc.) 1967 WheaTos at wark e P 196/_to 21. I certify that (I) (this haspital) attended the deceased from be retoined page 3 should e filed with the 1967, and that death occurred at 6 3M, from guses and on the date stated above O FUNERAL DIRECTOR: sow the deceased alive on. 22a SIGNATURE 22b DAJE SIGNED/ DIRECTOR PHYS PHYS 22d. ADDRESS TO HOSPITAL Poge 4 moy | 22c. PHYSICIAN'S NAME (Type) Whealan Aymon director, p 230 BURIAL CREMATION 23c. NAME OF CEMETERY OR CREMATOR) 23d LOCATION (City or Town) (State) REMOVA, (Specify) Cedar Hill Cenetery Suit 840 DRESS Georgia Hue. 25d RECD BY REGISTRAR Suitland 23 1967 23b REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR Inc. Funeral Home Silver SphatFAUG 25M 1/67 Pumptacey.

Land, No.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 30) W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 11201 HEALTH DERN PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institut an Residence before admission) o. COUNTY 2, and 3 to PM3. Page b. COUNTY MARYLAND delay i the State Department write RURAL and give nearest town? NAME OF HOSP TAL OR INSTITUTION (If not in hospitor, give street address) IS RESIDENCE ON A FARM? d STREET ADDRESS e, writing the ward "pending" in pencir in Item 18. Give Pages 1, 2 farwarded to the Chief Medical Examiner's Office along with farm NO X YES NAME OF 4 DATE Month Day y ear DECEASED (Type or print) DEATH 5 SEX 7 MARRIED NEVER MARRIED AGE (In years IF LADER 1 YEAR IF UNDER 24 HRS last birthdoy) Manths Dovs Hours after death. WIDOWED DIVORCED TDa USUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT State or foreign country) during mast of working yife, even if retired) INDUSTRY COUNTRY? pages 13 FATHER'S NAMI 14 MOTHER'S MAIDEN NAME event within 72 hours permit. File WAS DECEASED EVER IN U.S. ARMED FORCES? THE SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no. or unknown). (If yes give war ar dotes of service) 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) 4201 This certificate should DUF TO any Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse be used or remayal, PART II OTHER SIGNIF CANT CONDITIONS CONTRIBUTING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) 19 WAS AUTOPS PEREORMED? YES -20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) 3 shauld PRIMARY I or CONTRIBUTING I 4 shauld CAUSE OF DEATH crematian, MEDICAL 2Dc TIME OF NJURY Month, Doy, Year 20d INJURY OCCURRED 2De, PLACE OF INJURY (Hame, form, (City or town) (County) Hour o.m. foctory, street, office bldg., etc.) may be reto ned for your FUNERAL DIRECTOR: Page Not While of work 21 I certify that I taok charge af the remains described above, held an Autapsy [Inspection X and in my apinian buria, Natural causes funeral director. deoth resulted #13m. Surcide Homicide Undetermined mannér CHIEF MEDICAL EXAMINER 22. DATE SIGNED prior 1 ASSISTANT MEDICAL EXAMINER SIGNATURE Health NAME (Type) Literation of tounty) BURIAL PREMATION 23d LOCATION IC by or Tow 0 REMOVAL (Specify) 256 REGISTRAR S SIGNAT VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. feneral : 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland b COUNTY Montgomery o. COUNTY Montgomery MARYLAND on papers. Pages I Within 72 hours after c CITY OR TOWN (If auts de carporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 3 weeks 2 day Wheaton .⊑ d NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 3126 Helsel Drive Holy Cross Hospital NO TY NAME OF First Middle Lost 4. DATE Month Year and Completely DECEASED OF DEATH Helsel, Sr. Earl James 1967 August IF UNDER 24 HRS. S SEX 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years 7. MARRIED NEVER MARRIED 66 birthooy) Months Hours Dovs Male W Feb. 24, 1901 WIDOWED DIVORCED 100 SUAL OCCUPATION (Give kind of work some during most of working life, even fretred) he aidentitosTRY MIG S representative his unit ,10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT and in COUNTRY? U.S.A. Pennsylvania; Blair Co. 14 MOTHER'S MAIDEN NAME 13. FATHER S NAME ar remayal. George Helsel Clara Smith 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 579-22-8487 Mrs. LaGretta Glowacki signed by the attent burial-transit permit burial, crematian, a daughter None 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions if any, which gove rise to immediate cause (a). DUE TO stoting the underlying couse Page 4 may be retained by the haspital or attending as the priar to has been lost 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) NO P After this certificate 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MED CALEXAMINER) 20c. TIME OF N. JRY Month, Doy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home form, (City or town) ((ounty) (Stote) Hour To.m. Not While foctory, street, office bldg., etc.) of work 21. I certify that (1) (this hospital attended the deceased fram and that death accurred of 400 M, from causes and an the date stated above TO FUNERAL DIRECTOR: saw the deceased alive and 220 SIGNATUR ATTENDING director, page 3 shauld be filed w M.D DIRECTOR PHYS 22d ADDRESS PHYSICIANS O HOSPITAL 2309 Shorefie NAME (Type) 23d LOCATION (City or Town) 230 BURIAL CREMATION (County) (State) Burial (Specify) Parklawn Cemetery Rockville. Maryland 10. 1967 250 RECD BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Thorles VR A15 (4) 25M 1/67 Silver Spring



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11268

CERTIFICATE OF DEATH

377803

建		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
(IFE	1	o. COUNTY MARYLAND	G. STATE California b. COUNTY
a se te		b. CITY OR TOWN (If butside corporate limits, write RURAL and give nearest town) MARYLAND MARYLAND C LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town)
in by the rs. Pag Phours		Rockville	Del Mar
in l Prs. 2 hc		d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)	d. STREET ADDRESS 8 IS RESIDENCE ON A FARM?
Ny filled in John papers Within 721		Potomac Valley Nursing Home	1266 Cuchare Drive
A Signal	3	NAME OF First Middle DECEASED	Lost 4. DATE Month Doy Year
2 2 2		(Type or print) Catherine S. He	enderson DEATH August 10 19 67
and camplerali remover purb in day event, w	S.	SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED	8 DATE OF BIRTH 9. AGE (In years I FUNDER 1 YEAR 1 FUNDER 24 HRS Reb. 19. 1885 Months Doys Hours Min
8.5	L	remare Wille	7/5 VIS
	dur	o USUAL OCCUPATION (Give kind of work done https://www.schools.com/pg.most of working life, even if rehired) INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY?
cian	1	nousewile	New Jersey USA
a p	13.	FATHER'S NAME Henry Sciple	14. MOTHER'S MAIDEN NAME
an. by the attending physician transit permit. Then please cremation, ar remaval, and	L	•	? Reese
in di	15	WAS DECEASED EVER IN U.S. ARMED FORCES? (es, no, or unknown) (If yes give wor or dates of service)	INFORMANT 1153 Randolph Rd.
Ifter armi a, a			arguerite H. Peppin McLean, Va.
otio		18 CAUSE OF DEATH (Enter only one cause per line for (a) to, and (c).) PART I DEATH WAS CAUSED BY.	NTERVAL BETWEEN
r. × ≠ × ± znsi		IMMEDIATE CAUSE (a)	allungula 3 DALS.
ysician gned by rrial-tra rial, cre		DUE TO CONTRACTOR OF THE PROPERTY OF THE PROPE	On Alexander (molleilla) 5-400
physic signec burial burial		cond tions, if ony, which gove is to immediate cause (a).	xax virencesus (manging 3 9755
		stating the underlying couse DUE ID	I do no con al propio
attending has been e as the h priarta		lost) (c) CALLERALLY CO a	received as 10 yes.
atter has se as h pri	홍	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBOTING TO DEATH BUT NOT RELATED TO	PERFORMED?
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he haspit this certil etached Dept. af	MEDICAL	20c TIME OF INJURY Manth, Doy, Yeor 20d MifuRY OCCURRED 20e PL	ACE OF INDURY (Home form 20f (City or town) (County) (State) tory, street, office bldg., etc.)
by the free the decorate of th	≥	p.m. 17 of work — of work —	2/0/2
70 77 70		21. I certify that (I) (this hosp (a) attended the deceased fram_	//>5/67, 19, to_8/9/67_, 19, that (I) (we) last
be retained DIRECTOR: ge 3 should led with this		saw the deceased alive an 7/67 19, and the	at death occurred at 1 : 5 th, from courses and on the date stated above.
RECTO 3 sho with		Deury Mensker.	ATTENDING (MED. STAFF ()
		22c PHYSICIAN'S	22d ADDRESS
RAL Pod be fi		NAME (TypeHenry C. Scruggs	5413 Cedar Lane-Bethesda, Md.
Page 4 may O FUNERAL director, pa shauld be f	23	O BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR	CREMATORY 23d LOCATION (City or Town) (County) (State)
Pag edire sha	1	REMOVAL (Specify) Burial 8/12/67 West Laurel	Hill Philadelphia. Pa.
-		4 funeral Director Funeral Home 1331 Rocky:	250. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE
VR A15 (4) 25M 1/67	1,	Rockville Md.	ille Pike AUG 14 1967 filiantes Judge

O HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 haurs after



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11204

2:3			11203 CERTIFICATE OF DEATH
death	· San		PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
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事事			C LENGTH OF STAY IN 1b (CITY OR TOWN If guitside corporate limits write RIIRAL and give hearest town)
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filled in papers thin 72 h	11	11	ashmaten Janitarium & Hospital 10100 Gates Cive YES NO D
res that the death certificate be executed within 24 hours after isician. Isician. The by the attending physician and completely filled in by the function papers based in the please remark carbon papers. Pages in tremarian, or remayal, and in any event, within 72 hours after in crematian, or remayal, and in any event, within 72 hours after	,,		NAME OF First Middle Hensley OF Connas Hensley OF DEATH Quart 31 1967
The second secon		S	SEX 6 COLOR,OR RACE 7 MARRIED NEVER MARRIED 1 B DATE OF BIRTH 9 AGE (In years) IF UNDER 1 YEAR IF UNDER 24 HRS
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irtificate be ex physician and en please rem aval, and in an			USUA. OCCUPATION (Give kind of wark dane in growing life, even if retired) 105 KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY 3 FT.
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e death ce attending p permit. The an, or remo		15 fY#	WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address s, np, or unknown) (if yes give war or dates of service)
attendi permit. ian, or r		Ĺ	11es WWI Levens 1- Hospital Keroids 7600 Garroll QUE
that the death certifi an. by the attending phy transit permit. Then I			PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Once for (b) and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Once for (c) ONSET AND DEATH
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physical signer physical physi			Conditions, if ony, which gave) (b) (and of the fund
			rise to immediate couse (o). Stating the underlying couse DUE TO
art art			lost. (c)
AN: The law rall are attending trate has been far use as the Health priar to		NO.	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED?
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日音音号は		CERTIFICATION	20a. ACCIDENT WAS UNDERLYNG (2) OR CONTRIBUTING (3) OR CONTRIBUTING (4) OR CONTRIBUTING (5) OR CONTRIBUTING (6) OR CONTRIBUTING (7) OR CONTRIBUTING (7
NING PHYSI by the hast offer this cer be detached State Dept.		MEDICAL	20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, Haur'a.m. 20f (City or town) (Caunty) (State)
t + ± e e e e e e e e e e e e e e e e e e		꾶	Haur'a.m. Pm. 19 While Nat Wh.le at work at work factory, street, office bldg., etc)
			21. I certify that (1) (this haspital) attended the deceased from 8 - 3 , 19,67, to 8 - 31, 19,67 that (1) (we) last
Self Self Control			sow the deceased olive on 8/3/ 1967, and that death accurred at 4.40 AM, fram couses and an the date stated above.
OR ATTEN De retained HRECTOR: / e 3 shauld ed with the			220 SIGNATURE? AMD ATTENDING MED. STAFF 22b. DATE SIGNED / 57
TO HOSPITAL OR ATTE Page 4 may be retaine TO FUNERAL DIRECTOR director, page 3 shau shauld be filed with th	1		22c. PHYSICIANS NAME (Type) A Lan R Gair MD 7777 Maple Ave Tational Part MN
UNI UNI Becta		230	BURIAL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (State)
Page of FUN direct should			BURIALREM AUG. 31 MET BIG STONE CEM, BIG STONE GAP VA.
		24	FUNERAL DIRECTOR ADDRESS ST. N.W. 250 RECD BY REGISTRAR 256 REGISTRARS SIGNATURE 250 RECT TO THE PROPERTY OF
VR A15 (4) 25M 1/67			W. W. (HAMBERS, WH. HINGTON DC. DATE CED 6 1861.



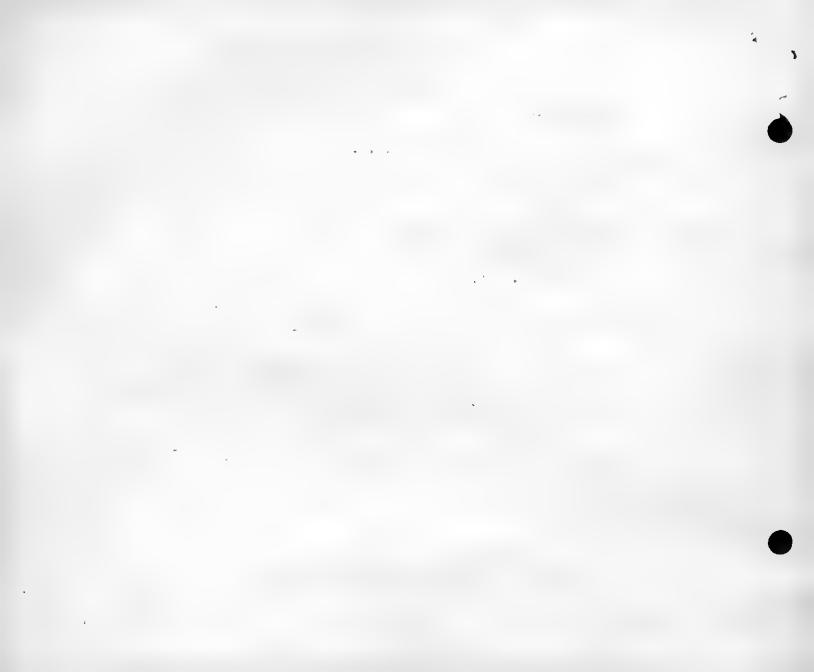
MARYLOND TOTE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11286 requires that the death certificate be executed within 24 hours after-death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY **b** COUNTY Montgomery MARYLAND Maryland by and Poges remove torbon papers. Pages of any event within 72 hours after b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and dive nearest town) write RURAL and give negrest town)
Bethesda (rural 2 days Chevy Chase .⊆ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Naval Hospital 4608 Chevy Chase Blvd NO 3c YES NAME OF Middle Lost 4 DATE Dov Year DECEASED (Type or pnnt) Thomas HICKEY Joseph DEATH AUGUST 30 IF UNDER 1 YEAR 6 COLOR OR RACE IF JNDER 24 HRS B DATE OF BIRTH AGE (n years 7. MARRIED XX **NEVER MARRIED** birthday) Months Hours March 7, 1902 WIDOWED Male Cauc. DIVORCED 10o USUA, OCCJPATION (G ve kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician creation please during most of working life, even if retired) INDUSTRY COUNTRY? St. Louis, Missouri USA 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME burial, cremotion, or remayal, Jeremiah Hickey Ann Lawton 17. INFORMANT Chevy Chase 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address Maryland (Yes, no, or unknown) (If yes give war or dates of service) Yes 489 34 4666 Mrs. Helen W. Hickey, 4608 Chevy Chase Blvd signed by the c burrol-transit p 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c), INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) Chronic Interstitial Pulmonary Fibrosis by the hospital or ottending physician. DUE TO Conditions, if any, which gove (b) rise to immediate couse (a), **DUF TO** stating the underlying cause be detoched for use as the Stote Dept. of Health prior to last. PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 146) WAS AUTOPS'
PERFORMED? Arteriosclerotic Cardiovascular Disease YES X NO F TO FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20o ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED (Crty or town) 20c. TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Home, form, (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work OR ATTENDING at work 21. I certify that A (this bespital attended the deceased fram August 28 19 67, to August 30, 19 67, that to (we) last ro Hospital or Attend Poge 4 may be retained sow the deceased alive on August 30 1967, and that death accurred at 200AM, from causes and on the date stated above director, page 3 should should be filed with the 22o. SIGNATURE/ 22b. DATE SIGNED STAFF August 30, 1967 M.D. DIRECTOR 22d. ADDRESS 22c PHYSICIAN'S NAME (Type) LT J. B. EMERY. MC/ USN Naval Hospital. Bethesda, Md 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURTAL, CREMAT ON, (Stote) (County) REMOVAL (Specify) 9-1-1967 Arlington, National Arlington. Virginia 24 FUNERAL DIRECTOR Joseph Gawler & Sons ADDRESS REC'D BY REGISTRAR 25h. REGISTRAR'S SIGNATURE 2So VR A15 (4) 5130 Wisconsin Ave. . N.W. Washington. D.C. 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11206 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY o. STATE b. COUNTY MONTGOMERY MARY. AND MONTGOMERY deloy h CITY OR TOWN (If autside corporate limits, c (ITY OR TOWN (If outside corparate in its write RURA, and give nearest town) r LENGTH OF STAY IN 16 oud write RURAL and give nearest tawn) P.M3. SILVER SPRING d NAME OF HOSPITAL OR, INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS ON A FARM? 2721 NORBECK RD. MONTGOMERY GENERAL HOSPITAL D.O.A. YES NO in Item 18. Give Pages 24 hours ofter deoth 3 NAME OF Last 4 DATE Month First Doy DECEASED 19 67 HOLLAND ELBERT WAYNE DEATH (Type or print) plong F., NDFR 24 HRS TELINDER 1 YEAR 5 SEX 6 COLOR OR RACE 8 DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARRIED Months Hours 5/18/60 D VORCED WHITE WIDOWED MALE 10a USUAL OCCUPATION (Give kind of work done TOP KIND OF BUSINESS OR 11 BIRTHPLACE (Stote or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY YORK, PENNSYLVANIA Chief Med col Exominer's 14 MOTHER'S MAIDEN NAME 13 FATHER S NAME This certificate should be executed within in penal ALVIN J. HOLLAND MELVINA RAFFENBERGER WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service in any event within SISTER AND MOTHER SAME NONE INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one cause per line for (o), (b), PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) writing the word DUE TO Conditions, if ony, which gove rise to immediate couse (a). forwarded to DUE TO stoting the underlying couse WAS AUTOPSY PERFORMED? PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION SWEN IN PART 1(0) or removel, þe 200 EXTERNAL CAUSE WAS RIBE HOW NORY OCCURRED (Enter noture of injust in Port Lor PRIMARY OF CONTRIBUTING CAUSE OF DEATH cremation, 20c TIME OF INJURY Month, Doy, Year Not While ot work 21 | certify that I took charge of the remains described above, held an Autopsy and in my apinion Inspection death resulted from Natural causes Accelent XI Suic de Hamicide Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE BELDEN R. REAP, M.D. YDW Health NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23o. BURIAL CREMATION. 0 REMOVAL (Specify) Silver Spring, Md. 8/21/67 Gate of Heaven Buria] yson Wheeler Funeral Home-1331 Rockville Pike AUG 21 1967 VR ATSME 6M 1/67 Rockville, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11208 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE h COUNTY MARYLAND E LENGTH OF STAY IN mils, write RURAO and give. hours RURAL and give nearest fewn) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs ć OR INSTITUTION (If not in hospitol, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? YES NO NAME OF Middle DATE First Day Year DECEASED 9 (Type or print) DEATH S. SEX 6. COLOR OR RACE 7 MARRIED 9. AGE (In years DATE OF BIRTH IF LINDER I YEAR IF UNDER 24 HR NEVER MARRIED last birthday) Months Days Hours **₩**IØOWED DIVORCED gud 100 USUAL OCCUPATION (Give kind of work done during most of working life, every vertired) 10b. KIND OF BUSINESS OR KETHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT INDUSTRY 13 PATHER'S NAME 14 MOTHER'S MA DEN NAME remayal, WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMAN 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates at service) 18. CAUSE OF DEATH (Enter only one couse per line for (b) (b), and (c).) .INTERVAL BETWEEN burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO tar use as the t Health priartab stating the underlying couse the haspital ar attending certificate has been last. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) NO 2Do ACCIDENT WAS JNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part 11 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF NIJRY Month, Day, Year 20d INTURY OCCURRED 2De PLACE OF INJURY (Home, form, (C'y or town) (County) (Stote) Hour om. foctory, street, office bldg., etc.) Not While Affer of work be retained by 21. I certify that (1) (this haspital) attended the deceased fram M, fram causes and on the date stated abave TO FUNERAL DIRECTOR: saw the deceased alive an 196 , and that death accurred at 220 SIGNATURE STAFF DIRECTOR PHYS director, page should be filed 22d ADDRESS O HOSPITAL 22c. PHYSICIAN NAME (Type) BURIAL, CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23o (County) 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11203 1,2:0 CERTIFICATE OF DEATH death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o COUNTY COUNTY ofter MARYLAND Montgome r LENGTH OF STAY IN 15 autside corporate la papers. Pag hin 72 haurs (ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hou HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENC h·n 721 ON A FARM? filled NO U carbon NAME OF Middle DATE Year DECEASED (Type or print) DEATH 19 6 S SEX AGE (In years lost b rthdoy) 6. COLOR OR RACE MARRIED NEVER MARRIED DATE OF BIRTH JE UNDER TYFAR F JNDER 24 HRS Months Doys Hours WIDOWED DIVORCED 4-23-10 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT 13 BIRTHPLACE (County & State or foreign country) physician (ien please during most of working life, even if retired) COUNTRY? ND JSTRY 13 FATHER S NAMI 14 MOTHER'S MAIDEN NAME Mary Susan Ratlieff WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) [(If yes give wor or dotes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per une for (e), (b), and (c) burial-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) 1120 DUE TO Conditions, if ony, which gove nse to immediate couse (o), DUE TO stoting the underlying couse has been the lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) WAS AUTOPSY far use Health r PERFORMED? 20o ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy, Year Not While G W Hour o.m. factory, street, office bldg, etc.) While of work 21 I certify that (1) (this hospital) attended the deceased from_ that (1) (we) las 26 196 Z, and that death accurred at 5 saw the deceased glive on Class M, fram auses and an the date stated above TO FUNERAL DIRECTOR: 220 SIGNATURE 22b DATE SIGNED ATTENDING STAFF # MD DIRECTOR PHYS 22r PHYSICIAN 22d. ADDRESS NAME (Type) G. Bowditch Hunter. Rockville, Md. 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Town) 23o. BURIAL, CREMATION (County) (State) Burial (Specify) Aug.30,1967 Damascus Meth. Damascus, Md. 24 FUNERAL DIRECTOR **ADDRESS** 2So. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE Olin L. Molesworth, Damascus, Md. 1967



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 112.0 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1,211 FOR STATE HEALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a COUNTY 2, and 3 ta PM3 Page **b** COUNTY any delay is 1, 2, and 3 ta Montgomera of MARYLAND enif b City OR TOWN (If outside corporate limits, LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corporate irrits, write RURAL and give nearest town) write RURAL and give nearest town) Stilte Departro Derwood. ET Desclo d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? please execute the certificate, writing the word "pending" in penal in Item 18. Give Pages 1, 's director. Page 4 should be farwarded to the Chief Medica: Examiner's Office along with farm NO E This certificate should be executed within 24 hours after death 3 NAME OF First Midd-e 4 DATE Month Inst Doy Year DECEASED 2010 DEATH S SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH last buthday) Months Doys WIDOWED DIVORCED and in any event within 72 hours after deat permit File pages 1 and 2 100 USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Woshington 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) INTERVAL BETWEEN burial-transit PART I DEATH WAS CAUSED BY: Exsanguatie MMEDIATE CAUSE (a) DUF TO Auto Accident. Conditions if any, which gove rise to immediate couse (a), stoting the underlying couse 0 last be used WAS AUTOPS)
PERFORMED? priar to bur al, cremation, or removal, PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G. VEN IN PART 1(a) 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port 1, of item 18.) FUNERAL DIRECTOR: Page 3 shauld PRIMARY OF CONTRIBUTING Wind spield when Car remed-Car in files. CAUSE OF DEATH 20c T.ME OF N.JRY Month Day Year (City or town) foctory, street, office bldg , etc) YOUR Not While eckville Nont-Inspection 💢 21. I certify that I took charge af the remains described above, held an Autopsy [Inquiry X. and in my opinian may be retained far the funeral directar. Accident A death resulted from Notural causes Suicide Undetermined monner Homicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE DEPLTY MEDICAL EXAMINER **EXAMINER'S** Health 1 NAME (Type) Address (Street, city, town, or county) DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town), BURIAL, CREMATION 50 250 REC'D BY REGISTRAR FUNERAL DIRECTOR VR A15ME (5) 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after Beath PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission), o COUNTY o. STATE b COUNTY MARYLAND C LENGTH OF STAY IN 16 c CITY OR TOWN outside corporate limits, write RURAL and give nearest town) papers. The hou INSTITUTION (If not in hospital, give street oddress IS RESIDENCE ON A FARM? 91 filled NO X YES TI, wash NAME OF pan Middle 4. DATE Month a Year DECEASED (Type or print) 1960 7 DEATH 7 yeors DATE OF BIRTH 9. AGE IF UNDER 1 YEAR UNDER 24 HRS 7 MARRIED NEVER MARRIED remaye and in ony ev birthday Months Dovs Hours WIDOWED DIVORCED and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 1) BIRTHPLACE (County & Stote, or foreign country) edse ing mest of working life, eyep of retired) INDUSTRY COUNTRY? attending physician sermit. Then please red-HOUSEWI FATHER'S NAME 14. MOTHER'S MAIDEN NAME cremation, ar remayal, UNENOWA 16 SOCIAL SECURITY NO WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT Address the, or unknown) (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line; for (a), (b), and (c). INTERVAL BETWEEN signed by the burial-trans.t PART I DEATH WAS CAUSED BY-ONSET AND DEATH IMMEDIATE CAUSE (o Page 4 may be retained by the haspital ar attending physician. 6 months Conditions, if any, which gove (b) rise to immediate couse (a), DUE TO far use as the t f Health priar ta b storing the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU! NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) WAS AUTOPSY PERFORMED? NO 20o ACC, DENT WAS UNDERLYING . 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of item 18.) OR CONTRIBUTING (C) CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (Stote) Hour 'o.m. factory, street, office bldg., etc.) Not While of work 21. I certify that (1) (this haspital) attended the deceased fram 19 6 That (1) (we) last director, page 3 shauld shauld be filed with the and that death accurred at & BM, from causes and on the date stated above. O FUNERAL DIRECTOR: sow the deceased olive on. SIGNATURE 22b. DAZE SIGNED **ATTENDING** M.D. PHYS DIRECTOR PHYS 22c. PHYSICIAN'S 22d ADDRESS NAME (Type) Benjamin Isaacson 230 BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) (County) REMQVAL(Specify) 8-23-1967 Buria National Memorial Park Falls Church Va. 24. FUNERAL DIRECTOR **ADDRESS** 25o. REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATUR VR A15 (4) 25M 1/67 Goldberg Funeral Home 4217 9th St., N.W.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11213 CERTIFICATE OF DEATH ely filled in by the funeral hope papers Pages 1 and within/72 haurs after deat PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 24 hours after dea o. COUNTY Montgomery o. STATE Maryland b. COUNTY MARYLAND Montgomerv b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If autside corparate limits, write RURAL and give negrest town) c. LENGTH OF STAY IN 16 write RUPAL and give nearest town) Cabin John Cabin John e IS RES DENO d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 7629 Cabin Road 7629 Cabin Road YES NO [PHYSICIAN: The law requires that the death certificate be executed within 3. NAME OF 4. DATE Middle First Lost Month Dov Year DECEASED DONALD HUNT IGLEHART AUGUST DEATH 19 67 (Type or pnnt) IF LINDER 1 YEAR IF UNDER 24 HR signed by the attending physician and campl burial-transit permit. Then please remave burial, crematian, or remaval, and in any evel DATE OF BIRTH 9. AGE (In years S. SEX 6. COLOR OR RACE 7 MARRIED **NEVER MARRIED** lost birthdoy) Months Dovs Hours Male Caucasian 10/4/03 WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
Architect **COUNTRY?** INDUSTRY Architectural Washington, D. C.
14 MOTHER'S MAIDEN NAME USA 13. FATHER'S NAME Thomas G. Iglehart Olga Ulrich 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Same as (Yes, no, or unknown) (if yes give wor or dates of service No 216-40-9994 Mrs. Frances L. Iglehart. Wife #2 above INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: ONSET AND DEATH ARREST IMMEDIATE CAUSE (o) by the hospital ar attending physician. 4 201 DUE TO MYOCARd. INFARCTION Conditions, if ony, which gove use to immediate couse (o), DUE TO stating the underlying couse as the SCIEROSIS CORUNARY ARTERY la st WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION be detached for use State Dept. of Health YES NO certificate 20a. ACCIDENT WAS UNDERLYING [20b, DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1! of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED (Stote) 20e PLACE OF INJURY (Home, form, (City or town) (County) 20c. TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Hour 'o.m. Not While of work OR ATTENDING ot work 21. I certify that (1) This haspital) attended the deceased from. TO HOSPITAL OR ATTENDII
Page 4 may be retained by
TO FUNERAL DIRECTOR: Aft AUG 1967, and that death occurred at 8 A M, fram causes and an the date stated above. saw the deceased alive on (1) 22a. SIGNATURE 22b. DATE SIGNED **ATTENDING** PHYS. directar, page 3 should be filed v M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) 24Th. St. N.W. Washington.D.C. DR. CHARLES W. 703 THOMPSON 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION 23b DATE THEREOF (County) REMOVAL (Specify) Rock Creek Cemetery Burial Washington. 256 REGISTRAR'S SIGNATURE ADDRESS. 250 REC'D BY REG STRAR 24 FUNERAL DIRECTOR Melianes VR A15 (4) Joseph Gawler's Sons, Inc., Wash., D. C. 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11213 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE b COUNTY Marvland Carrol1 MARYLAND 24 hours after Montgomery b CITY OR TOWN (If autside corparate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) fin 72 hours Olney Md Ida
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Iday Sykesville. d STREET ADDRESS IS RES DENCE aper ON A FARM? NO PC Montgomery General Hospital Box 244 Rt# OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within NAME OF Middle OATE Manth Day Year DECEASEO 8 19 67 (Type or print) **OEATH** Jenkins Bessie IF UNDER 1 YEAR SEX 9 AGE (In years JE UNDER 24 HRS 6. COLOR OR RACE 7 MARRIED NEVER MARRIED B. OATE OF BIRTH remove last birthday) Months and in any WIDOWED DIVORCED 1-9-95 and 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during mast of working life, even if retired)
Housewife COUNTRY? INDUSTRY Maryland 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar removal, Maryann Hughes 01 Sam_Ridgely IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown). ((If yes give war ar dates of service) 17. INFORMANT 16. SOCIAL SECURITY NO. permit. cremation, 18. CAUSE OF DEATH (Enfer any one cause per line for (a), (b), and (c).) burnal-transit PART I. OFATH WAS CAUSED BY IMMEDIATE CAUSE (0) HOUTE burial, Canditions, if any, which gave rise ta immediate cause (a). DUE TO priar to stating the underlying cause has been last. PART II. OTHER SIGNERCANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(o) WAS ALTOPSY PERFORMED? ELLITUS NO DX 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH be detached State Dept of (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Month, Oay, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (Caunty) (Stote) Hour am. foctory, street, office bldg., etc.) at work at wark I certify that (I) (this haspital) attended the deceased from 7-31-57 , 19 , ta 8-1-67 , 19 , that (I) (we) las _____19_____, and that death accurred at 6:224M, from causes and on the date stated above saw the deceased alive on 8-1-676 22b DATE SIGNED 22a SIGNATURE M.D. PHYS DIRECTOR 22d ADDRESS 222 PHYS CIAN S NAME (Type) ONTGOMERS director, 23c NAME OF CEMETERY OR CREMATORY BUR AL CREMATION. (Caunty) 2So REC'D BY REGISTRAP 2Sb REG STRAR S SIGNATURI 24. FUNERAL OIRECTOR VR A15 (4) f 25M 1/67



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission a. COUNTY The law requires that the death certificate be executed within 24 hours after MARYLAND autside carparate limits. c. LENGTH OF STAY IN 16 CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give neorest town) STLVER SPRING VERSPRING d. street ADDRESS 8625 Piney Branch Rd. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) IS RESIDENCE ON A FARM? NO F NAME OF Middle Lost DATE DECEASED OF DEATH S SEX 8. DATE OF BIRTH 9. AGE (In years BELINDER 1 YEAR 7 MARRIED last birthdoy) WIDOWED 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT during most of work ng life, even if retired) COUNTRY? **LYSTSHOW!** WASHINGTON 13. FATHER'S NAME cremation, ar remayal, 16. SOCIAL SECURITY NO 17 INFORMANT Nursing Home Records 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH Infarction erebra IMMEDIATE CAUSE (o) DUE TO Cerebra Conditions if only, which gave rom besis rise to immediate couse (a), DUE TO stating the underlying cause Lere brovascular Disease Teriosclerolic WAS AUTOPS PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 20g ACCIDENT WAS UNDERLYING [205, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Yeor Hour a.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or fown) (State) (County) TO FUNERAL DIRECTOR: After this foctory, street, affice bldg., etc.) Nat While ot work ded the deceased from_______, 19(03) ta Aug 25, 19(07), that (1) (we) las 22 19(07), and that death accurred at 6:30 PM, from causes and an the date stated above 21. I certify that (I) (this haspital) attended the deceased from saw the deceased alive an 220 SIGNATURE 22b. DATE SIGNED MED. DIRECTOR STAFF PHYS. **ATTENDING** 45.67 M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) John F Gustafsbn 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL, CREMATION, 23b DATE THEREOF 23d. LOCATION (City or Town) REMOVAL (Specify) Prince Georges County. 8/26/67 Ft. Lincoln Cemeter 24. FUNERAL DIRECTOR he S.H. Hines Company VR A15 (4) 20 M 1/66 14th St. N.W. Washington,

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. COUNTY o. STATE MARYLAND and 2 with the State Department c LENGTH OF STAY IN 16 write RURAL and give nearest town a Koma d STREET ADDRESS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ON A FARM th NAME OF DATE Year DECEASED 1967 DEATH IF UNDER 1 YEAR S SEX 7 MARRIED AGE (In years IF JNDER 24 HRS lost birthdoy) Months event within 72 hours after death WIDOWED 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR. 12. CITIZEN OF WHAT during most of peopling life, even if retired) pencil in 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME 12000 wrain IS WAS DECEASED EVER NULS ARMED FORCES? 16 SOCIAL SECURITY NO INFORMAN This certificate should be executed (Yes, no, or unknown) (If yes give war or dates of service 18 CAUSE OF DEATH (Enter only one couse per line for (o), PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) **DUE TO** Conditions if any, which gove) rise to immediate couse (a) arwarded to DUE TO stating the underlying couse remayal, 19 WAS AUTOPS PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter nature of Injury in Port Lor Port Lof Item 18) 3 shauld PRIMARY I or CONTRIBUTING I CAUSE OF DEATH. 20d INJURY OCCURRED 20e PLACE OF .NJURY (Home, form, 20f (City or town) 20c. TIME OF INJURY Month, Doy, Year (Stote) foctory, street, office bldq, etc } Hour o.m. Not While FUNERAL DIRECTOR: Page of work U of work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection | and in my opinion death resulted frest? Natural causes Suicide . Hamicide Undetermined manner the funeral d rector CHIEF MEDICAL EXAM.NER ACTUAL 22. DATE SIGNED TO FUNERAL D ASSISTANT MEDICAL EXAMINER SIGNATURE **EXAMINER'S** NAME (Type) NAME OF CEMETERY OR CHEMATORY 23c LOCATION (City or Tow 230 BUR AL CREMATION, 23b DATE THEREOF Burial Ft Lincoln Cemetery 1967 Colmar Manor Pro Geo Md. AUG 8 1967 256 24 FUNERAL DIRECTOR VR A15ME (5) F. Gasch's Sons Hyattsville, Md. 6M 1/67



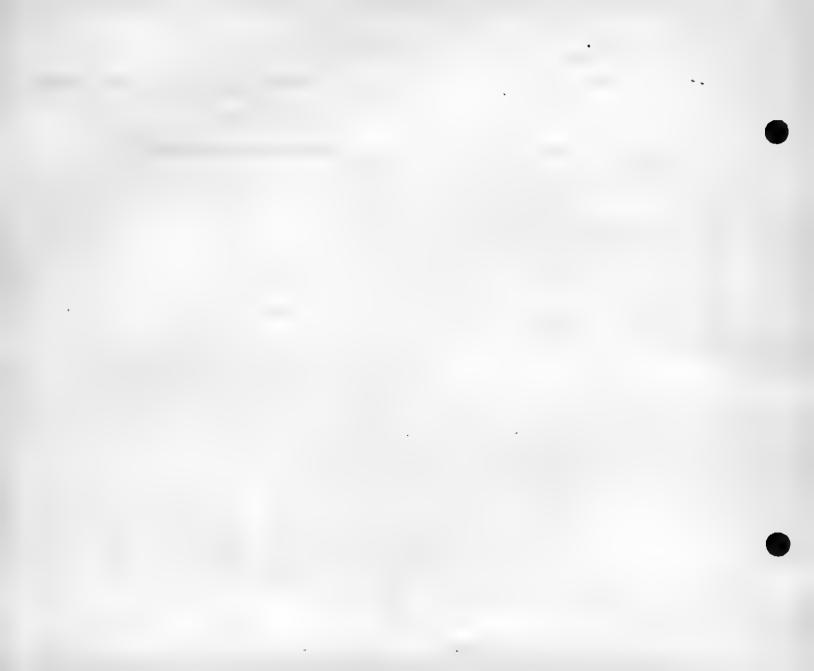
1. 10	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
	11216 CERTIFICATE OF DEATH	
attending physician. has been signed by the attending physician and completely filled in by the funeral ise as the burial-transit permit. Then please remave cotron papers. Pages I and 2 th priar ta burial, crematian, ar remaval, and in any event, within 22 haurs after death	DESCRIPTION OF DEATH O. COUNTY MARYLAND 1 PLACE OF DEATH O. STATE D. COUNTY MARYLAND MARY	7
n by the s Pages haurs af	b CITY OR TOWN (If outside carparate limits, write RURAL and give nearest fawn) write RURAL and give nearest town) Wheaton d NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDEN	VČĖ.
filled i	University Nursing Home as above YES No	M?
ompletely tilled ve company with within the company of the company	3 NAME OF DECEASED (Type or print) Susan Filen Johnson BATE (In years FLMDER YEAR FUNDER 24 SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In years IFLMDER YEAR IF UNDER 24 In years IFLMDER YEAR YEAR	4 HRS Min
and in any	Female Negro WIDOWED DIVORCED 9/9/1889 77 yrs North Down Strain S	
ng physic Then ple emaval, c	13. FATHER'S MAME Oscar Thomas Hattie	
attendi permit. ian, ar n	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 235-80-3255 Mrs. 'Harriet Wood-5024 Eastern Ave., NE. 18. CAUSE OF DEATH (Enter only one couse per **ng*(6) (0), (b), and (c))	-FN
arrenaing physician. has been signed by the attending physician and comise as the burial-transit permit. Then please remave h priar ta burial, crematian, ar remaval, and in any ex	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if ony, which gove rise to immediate cause (a), stating the underlying cause lost (c) Conservation to the course (a), stating the underlying cause lost	
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thed far pt. af He	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18)	
trer inis be deta state De	20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 While at work at the deceased from 19 work 19 with the deceased from 19 work 19 with the deceased from 19 with the deceased	
shauld th the	saw the deceased alive an 1967, and that death accurred at AM, from causes and an the date stated a	bave
rage 4 may be retained by the haspital of arenaing 10 FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the shauld be filed with the State Dept. of Health prior to	M D ATTENDING MED. STAFF DIRECTOR DIREC	חר.
director, shauld b	230 BURIAL CREMATION, REMDYN (Sign of County) (Sign of Co	e)
R A15 (4) I M T/66	FUNERAL PRESTOR ADDRESS 3015 12th St., C. DATE AUG 2 2 1987 Cliantes Judge	-



	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	11217 Ttem #1d Film #177 Print #18 DEATH
1	1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decressed lived, If institution; Residence before edmi
	MARYLAND STATE MATURAL . b. COUNTY MUNTS OMET.
	b. CITY OR TOWN (if outside corporate limits, / t. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give reacest lown)
	write RURAL end give neerest town)
ı	d. NAME OF HOSPITAL-OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. 15 RESIDI
	OFFICE II THE CONTRACTOR ON A FA
, ,	3. NAME OF First Middle Last 4. DATE Month Day Year
Ì	DECEASED
9	last birthday) Months Days Hours M
Ĺ	113 WIDOWED DIVORCED JU1/19, 1890 77 yrs.
	10a. USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COU
	Merchant Kussia U.S A
1	13. FATHER'S MAIDEN NAME
	Hyman Kagan Chana -
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yas, no, or unknown) ((Ifyesgive wer or dates of service)
	no lie Kaganiwife - Same
Ī	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
	PART I. DEATH WAS CAUSED BY, MUCCAFOLD STATE ONSET AND DEAT
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l	A Tobac to Till Continue to
	gava rise to immediate cause
ı	(a), stating the underlying DUE TO cause last,
l,	(6)
1	PERFORM
1	YES NO' 206. ACCIDENT WAS UNDERLYING 206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
1	■ OP. CONTRIBUTING [] CAUSE OF DEATH
П	
1 3	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 19
1	
	21. I certify that (I) (this hospital) attended the deceased from
	saw the deceased alive on
1	22a. SIGNATURE 22b. D ATTENDING MED. STAFF STAFF
	M.D. PHYS. DIRECTOR PHYS. D
	22c. PHYSICIAN'S NAME (Type) May to Alter to lay the Description of the Single
	MAME (1900) MOTEN Altschuler M.D 19705. New 12 mg chieftre Sating
3	236. BURIAL, CREMATION, 236 DATE THEREOF (23c. NAME OF CEMETERY OR CREMATORY) (Siele)
	Burial 8/13/67 King David Mem Garden Falls Church, Va.
1	24 FUNERAL DIRECTOR'S SUSTRATURE ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE
	13. Any austy star- 35° 1-14 The partie 15 1967 Minutes Judge
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH re carban papers. Pages 1 and 2 Event, within 72 haurs after death. 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY MARYLAND TOWN (If outside corporate limits c CITY OR TOWN (if autside corparate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 write RURAL and give nearest town) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hour OCKUILLE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS filled ON A FARM? I NO D NAME OF First Middle 4 DATE Day Year DECEASED MINNE AUFMAN AUGUST (Type or print) DEATH 19 6 S. SEX 6. COLOR OR RACE DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR LIE UNDER 24 HRS 7 MARRIED **NEVER MARRIED** last birthdoy) 3-15 WIDOWED DIVORCED and o 10a USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. EITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? RUSSIA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remaval, DANICK ZEV CHAVA IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT ROCKVILLE MAD (Yes, na, ar unknown) (If yes give war ar dates of service) 4004-BLAKAPOOL RD burial, cremation, 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY: INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) DIFE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying couse Inst PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? NO V ficate 20o. ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) Hour 'o.m. Not While foctory, street, office bldg., etc.) ot work at work 2). I certify that (1) (this haspital) attended the deceased framework and 1966, ta and 1, 1967, that (1) (we) last director, page 3 should should be filed with the TO FUNERAL DIRECTOR: saw the deceased alive an area (1967), and that death accurred at 2 25 M, fram causes and an the date stated above 220 SIGNATURE 22b DATE SIGNED M.D DIRECTOR 22d ADDRESS 22c PHYSICIAN S SPRING NAME (Type) (EVE SILVER SPRING 230 BURIAL CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23b. DATE THEREOF 23d LOCATION (City or Tawn) (County) (Stote) REMOVAL (Specify) WORKMEN'S CIRCLE CEM-BALTIMORE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE VR A15 (4) WASHINGTON DC Charley Judge DATE AUG BERNARD



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH transit permit. Their please remove corbon papers. Pages 1 and 2 cremation, or removal, and in ony event, within 72 hours, after death land 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY MONTGOMERY MARYLAND MARILLAND. MONT COMER by 11. Pages b CITY OR TOWN (If auts de carparate (mits.) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town) write RURAL and give nearest tawn) WHEATON WHEATON be executed within 24 hours d STREET ADDRESS IS RESIDENCE ON A FARM? completely filled in d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) NO 3 NAME OF Middle Last 4 DATE Month Day Year DECEASED 21 ALFRED 19 DEATH (Type or pant) IF UNDER 1 YEAR IF LINDER 24 HRS SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED 9. AGE (In years PHONE lost b rthday) Months Davs Haurs DIVORCED 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 10g USUAL OCCUPATION (Give kind of work done offending physics. during most of working life even if retired **COUNTRY?** UNDUSTRY NEW YORK RETIRED 13 FATHER'S NAM 14. MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANT S-GALAUE. SSPEL CAUSE OF DEATH (Enter only one cause per lyne for (a), O FUNERAL DIRECTOR: After this certificate has been signed by the director, page 3 should be detached for use as the burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) be retained by the hospital or ottending physician. DUE TO 3 should be detached for use as the burial-with the State Dept. of Health prior to burial, Conditions, if any, which gove rise to immediate cause (o). DUE TO stoting the underlying couse last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING/TO DEATH BUT NOT RELATED TO THE/JERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CERTIFICATION NO 205. DESCRIBE HOW INJURY OCCURRED (Enter follying of injury in Port 1 or Port II of Item 18) 200 ACCIDENT WAS UNDERLYING ... OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, affice bldg., etc.) Hour a.m. at work 21. I certify that (1) (this hospital) attended the deceased fram. 19 6 7 and that death accurred at M, from causes and an the date stated above saw the deceased alive an 22b. DATE SIGNED 220. SIGNATURE DIRECTOR PHYS M.D director, page should be filed 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) DATE THEREOF NAME OF CEMETERY OR CREMAJORY LOCATION (City or Town (County) BURIAL, CREMATION 2So REC'D BY REGISTRAR 196 VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

11221

12 CITIZEN OF WHAT

COUNTRY?

e S RESIDENCE ON A FARM?

YES NO

19 67

USA

IF JNDER 24 HRS

INTERVAL BETWEEN

ONSET AND DEATH

19. WAS AUTOPSY PERFORMED?

NO

YES TOTAL

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11220 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) **u.** COUNTY Montgomery MARYLAND West Virginia b CITY OR TOWN (If autside carporate limits, write RURAL and give nearest tawn) c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest town) Bethesda (rural 10 days Sutton d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Naval Hospital Box 144 Herold Route NAME OF Middle First 4. DATE Manth DECEASED Jeffrey Dean KEENER August (Type or print) DEATH 5. SEX 6 COLOR OR RACE NEVER MARRIED 8. DATE OF BIRTH 9 AGE (in years IE UNDER 1 YEAR 7 MARRIED birthday) Male Cauc Jan. 27, 1960 WIDOWED DIVORCED 10a SUAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) INDUSTRY Wurtsmith, Michigan 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Emma Jean Rose George D. Keener 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Sutton, W. Va. 16. SOCIAL SECURITY NO (Yes, na, or unknown) (If yes give war ar dates af service) Mr. George D. Keener, Box 144 Herold Route 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY CONGENITAL HEART DISEASE IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave (b) nse ta immediate cause (a), DUE TO stoting the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) 20o ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part 11 of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER

20d. INJURY OCCURRED 20e PEACE OF INJURY (Hame, farm, 20c. TIME OF INJURY Month, Day, Year (City or town) (County) (State) Наит а.т. Nat While at work foctory, street, office bldg., etc.) at wark 21. I certify that \$\pi\$ (this haspital) attended the deceased from August 15, 19 67, to August 2519 67 that (1\(\frac{1}{2}\)(we) lost sow the deceased alive on Anguet 25 1967, and that death accurred also M, from causes and on the date stated above 22a. SIGNATURE 22b. DATE SIGNED Aug. 25., 1967 DIRECTOR PHYS

22d. ADDRESS

Naval Hospital, Bethesda, Md

23a BURIAL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) Burial-transit 8-26-67 Family Cemetery Sutton, West Virginia 256 REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR ROBert A. Pumphrey ADDRESS 25a. REC'D BY REGISTRAR Funeral Home, 7557 Wisconsin Ave., Bethesda, Md AUG 28

VR A15 (4) 25M 1/67

TO FUNERAL DIRECTOR: After this certification, page 3 shauld be detoched

requires that the deoth certificate be executed within 24 hours after death.

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O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 moy be retained by the haspital or ottending physician.

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22c PHYSICIAN'S

NAME (Type)

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH gapers. Pages 1 ond hin 72 hours after deoi o. COUNTY o. STAJE b. COUNTY montgomery Montgowery MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (If outside corporate limits, write RURAL and give negross town) € LENGTH OF STAY IN 16 d. STREET ADDRESS campletely filled in d. NAME OF HOSPITAL OR INSTITUTION (If notin hospital, give street address) ON A FARM? 2230 YES NO K DATE NAME OF Middle Month Year OF DECEASED event DEATH (Type or print) COL SEX AGE (In years 7 MARRIED lost b rthday) ottending physicium um armove Months WIDOWED DIVORCED buriol, cremation, or removal, and in any 12 CITIZEN OF WHAT 1Db. KIND OF BUSINESS OR COUNTRY? during mast of working life, even if retired) INDirSTRY 13. FATHER'S NAME 16 SOCIAL SECURITY NO INFORMAN 2nd -05-7089 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) signed by the buriof-transit p PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Poge 4 may be retained by the hospital or attending physicion. DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse FUNERAL DIRECTOR: After this certificate has been be detached for use os the Stote Dept. of Health prior to lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPSY PERFORMED? NO F 205. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 2De. PLACE OF INJURY (Hame, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) Hour o.m Not While 19 ot work 21. I certify that (I) (this haspital) attended the deceased from Mesch 20, 1967, taller of saw the deceased alive an 42 p. 17 1967, and that death accurred at 65 p.M., from accuses and directer, page 3 should should be filed with the an the date stated above DATE STGNED 22o. SIGNATURE MED. DIRECTOR **ATTENDING** M.D. PHYS 22d. ADDRESS 22c PHYSICIAN S NAME (Type) DATE THEREOF 23 23d (County) (Stote) 23o. BURIAL, CREMATION, REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11223 MEDICAL EXAMINER'S CERTIFICATE OF DEATH MIALTH DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, funstitution Residence before admission) COUNTY a STATE **b** COUNTY Page State Department of MONTGOMERY MARYLAND deloy HOWARD b CITY OR TOWN (If outside corparate timits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 c CTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ond , 2, c. PM3 Olney DOA & NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? farm in Item 18. Give Pages NO -YES Montgomery General Hospital 24 hours after death. olong with NAME OF 4 DATE Last Manth Day DECEASED OF (Type or print) Charles Nicholson Kendall DEATH SEX 7 MARRIED X 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years F UNDER I YEAR IF UNDER 24 HRS NEVER MARRIED last birthday) Manths Davs WIDOWED DIVOR CED 8/21/01 65 yrs. Office puol On USUAL OCCUPATION (Give kind of work done 10b. K ND OF BUSINESS OR 1: BIRTHP.ACE (State or fareign country) 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Retailer Ithica, Ny Examiner's General Store within pencil 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Mabel Crawford Pranklin Kendall 15 WAS DECEASED EVER IN U.S. ARMED FORCES? This certificate should be executed 16 SOCIAL SECURITY NO. 17. INFORMANT (wife) Address the Chief Medica (Yes, na, ar unknown) (if yes give war or dates of service) event within 212-34-3911 Mary P. Kendall Clarksville, Maryland 18 CAUSE OF DEATH (Enter only one couse per line to (a). ANTERVAL BETWEEN burial-tronsit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE (AUSE (o) word DUE TO Conditions, if any, which gave te, writing the v forworded to the rise ta immediate cause (a), \subseteq DIJE TO stating the underlying couse o. lost removal, PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMS A. D. SEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS CERTIFICATION PERFORMED? NO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Port II of item 18.) 3 should PRIMARY OF CONTRIBUTING should ö CAUSE OF DEATH 20f (City or tawn) (Caunty) 20c TIME OF NURY Month, Day, Year 20d NJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (State) Hour o.m. factory, street, affice blda., etc 1 moy be retained for your FUNERAL DIRECTOR: Page Nat While at work at wark 21. I certify that I took charge of the remains described above, held on Autopsy inspection 🔀 and in my opinion the funeral director. death resulted from. Natural causes Accident Suicide [Hamicide Undetermined manner CHIEF MEDICAL EXAMINER Health prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE 236 DATE THEREOF 23d LOCATION (City or fown) 0 Aug.17,1967 St. Marks Highland, Md 2Sa REC D BY REGISTRAR 25b REGISTRAR S SIGNATURE VR A15ME (5 Migimbothom-Slack, Ellicott City, Md 6M 1/67 1967



CERTIFICATE OF DEATH Rea. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNTY b. COUNTY MARYLAND NTGOMER YONTGOMERY b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) BETHESDA THESDA d. NAME OF HOSPITAL (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE OR INSTITUTION RIVER YES 📉 NO 🔃 NAME OF 4. DATE First Middle Month Year Day DECEASED OF DEATH (Type or print) 196 IF UNDER 1 YEAR IF UNDER 24 HRS. 5. SEX 6. COLOR OR RACE 7. MARRIED MEVER MARRIED 9. AGE (In years buthday) Months Doys Hours DIVORCED WIDOWED | 10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State at foreign country) 12. CITIZEN OF WHAT COUNTRY? ELLEFONTAINE 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME RENCE PLINGER WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address HOOLESVILLE 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED 8Y: TERIOSCLEROTIC SEVIYRS IMMEDIATE CAUSE (a) **DUE TO** Conditions, if ony, which gove rise to immediate **DUE TO** cottle (a), stating the underlying couse lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO DE 20g. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Port I or Port II of item 18.] 20c. TIME OF INJURY Month. .. 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) Day, Year (County) (State) factory, street, effice bldg., etc.) Hour a.m No! while at work of work 1967, to AUGUST 6, 1867, that I last saw the deceased 21. I certify that I attended the deceased from Ju , and that death occurred at 6:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE NAME (Type) DATE THEREOF 220. BURIAL CREMATION. 22b. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) REGISTRARY SIGNATURE 23. FUNERAL DIRECTOR'S SIGNATURE **ADDRESS** 24a. REC'D.BY, REGISTRAR 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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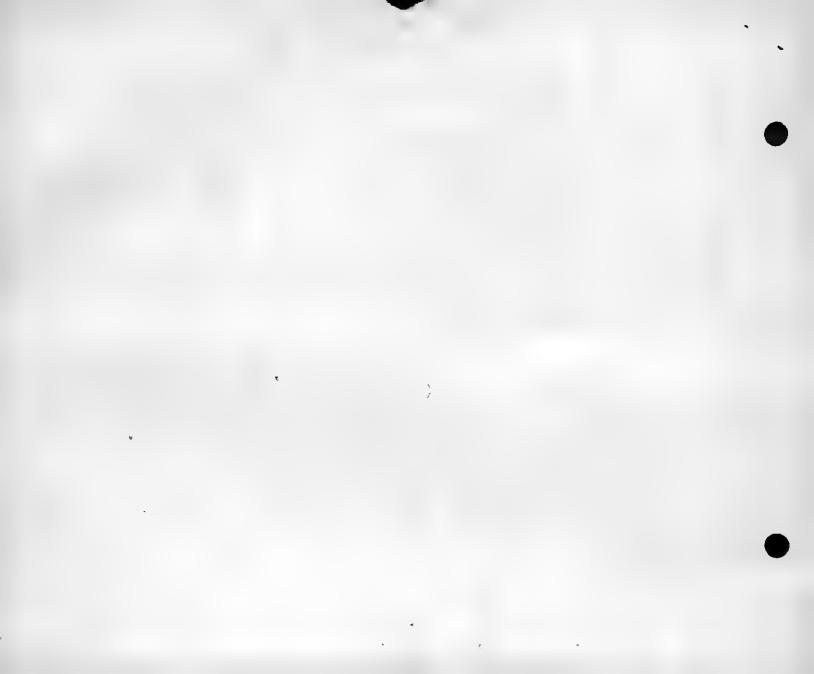
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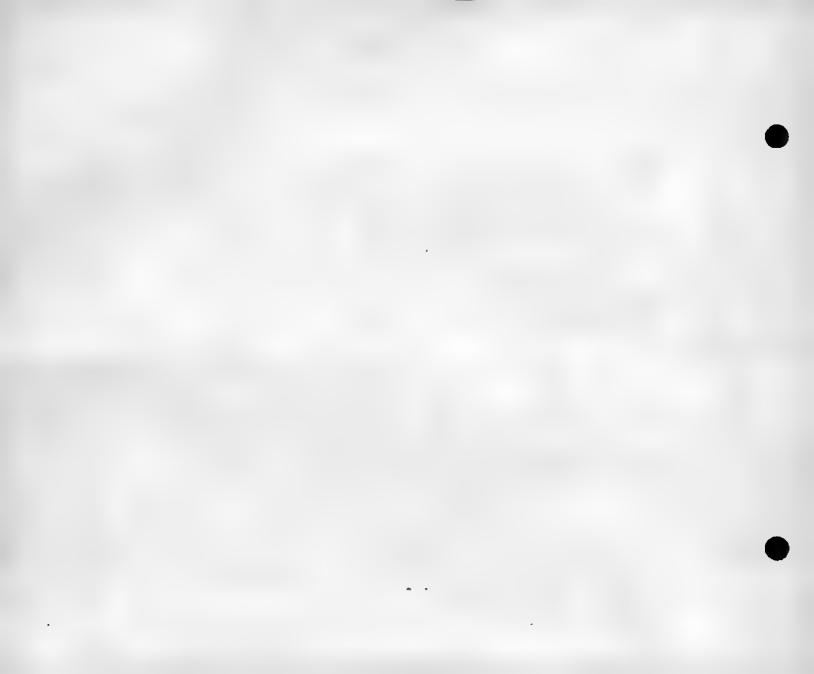
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased fived, if institution Residence before admission) campletely filled in by the funera o. COUNTY o. STATE b. COUNTY lon I gomes MARYLAND b CITY OR TOWN (If outside corporate limits, ¢ TENGTH OF STAY IN 16 write RURAL and give nearest town) 113. d. NAME OF HOSPITA, OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? YES X NO 3 NAME OF 4 OATE Month Lost Year OECEASED
(Type or print) Cornelis Robert NE PRELHOLT DE STERKENSUR 19 DEATH SEX 6. COLOR OR RACE AGE (In yeor 7 MARRIED NEVER MARRIED Months lost birthdov) Dovs Hours Wh WICOWEO and (10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT please during most of working ite, even if retired) INCUSTRY COUNTRY? DOOLN NETHOLLAND NE PHETCLAND 13. FATHERS NAME 14. MOTHER'S MAIOEN NAME KNEPPELHOUT VAN STERKENS CURNELIA SCHUULBEKE WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dotes of service) INTERVAL BETWEEN 1B. CAUSE OF OEATH (Enter only one couse per line for (o), (b), and (c),) signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gove rise to immediate couse (a), DUE TO stating the underlying couse as the has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY PERFORMED? State Dept. of Health NO X YES O FUNERAL DIRECTOR: After this certificate Ē 20o ACCIDENT WAS UNDERLYING [205. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Ooy, Year 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Not While foctory, street, office bidg, etc.) ot work 1952-10 21. I certify that (1) (this hospital) attended the deceased from 19.67, that (1) (we) last 1967, and that death accurred at 24. M, fram causes and on the date stated above. saw the deceased alive an director, page 3 sha 22b. DATE SIGNED 22o. SIGNATURE **OIRECTOR** 22d. ADORESS 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23da LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b. OATE THEREOF (County) REMOVAL (Specify) 24. FLINERAL DIRECTOR VR A15 (4) OATE AL 20 M 1/66.1



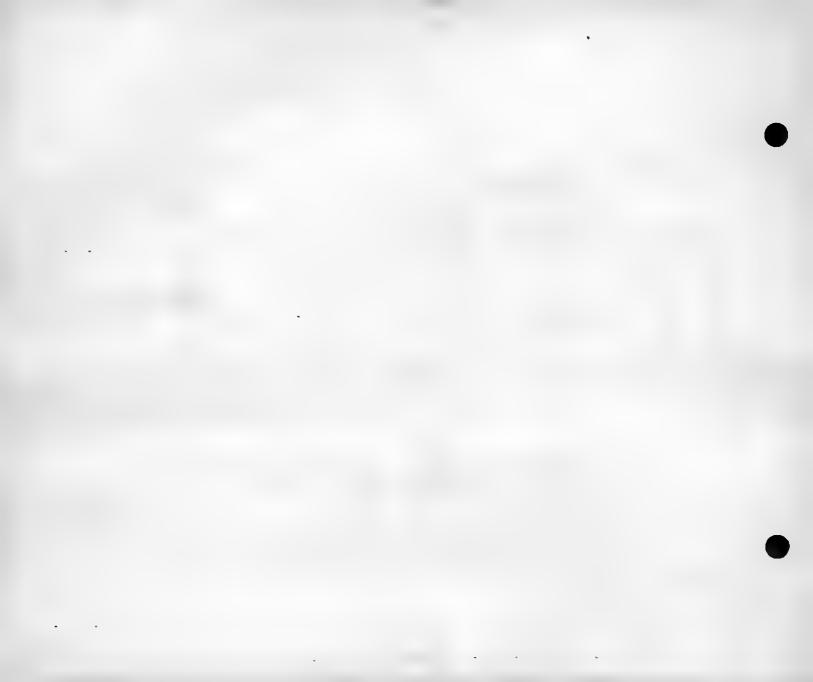
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11226 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY g. STATE MARYLAND b CITY OR TOWN (If outside corparate imits c LENGTH OF STAY IN 15 outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? YES NAME OF Middle 4 DATE carban Lost DECEASED (Type or print) DEATH S SEX 6. COLOR OR RACE IF UNDER I YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH AGE (In years ost birthday) Months Days WIDOWED DIVORCED 10a. US JAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life even if retired) INDUSTRY COUNTRY? UNDUMAT 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT (Yes, no, of unknown) (If yes give war ar dates of service 5 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any which gave 1 rise to immediate cause (a), **DUE TO** stating the underlying cause Papillary serous cystaneocarcinoma) has been last. OS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPS' PERFORMED? Tumor perforation of ileum with loculated purulent peritonitis. YES X NO 20g, ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year 20e PLACE OF INJURY (Hame, farm 20f. (City or town) (County) (State) Hour 'a.m. factory, street, affice bldg., etc.) While Not While at work 21. I certify that (1) (this haspital) attended the aeceased fram_ 10-22-1900 in 8-13-1907, that (I) (we) last Poge 4 may be retained 19 67 saw the deceased alive an , and that death accurred at 3/2A M, fram causes and an the date stated above O FUNERAL DIRECTOR: 22a, SIGNATURE 22b DATE SIGNED director, page 3 should be filed v M.D. DIRECTOR Old Georgetown 22c. PHYSICIAN'S NAME (Type) RONALD Maryland Bethesda. 230 BURIAL, CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Fawn) (County) REMOVAL (Specify)
Cremation Ft. Lincoln Crematory Prince George County, Md 8-15-67 25b. REGISTRAR'S SIGNATUR UMPHREY, Bethesda, Maryland 2So REC'D BY REGISTRAR Charles DATE



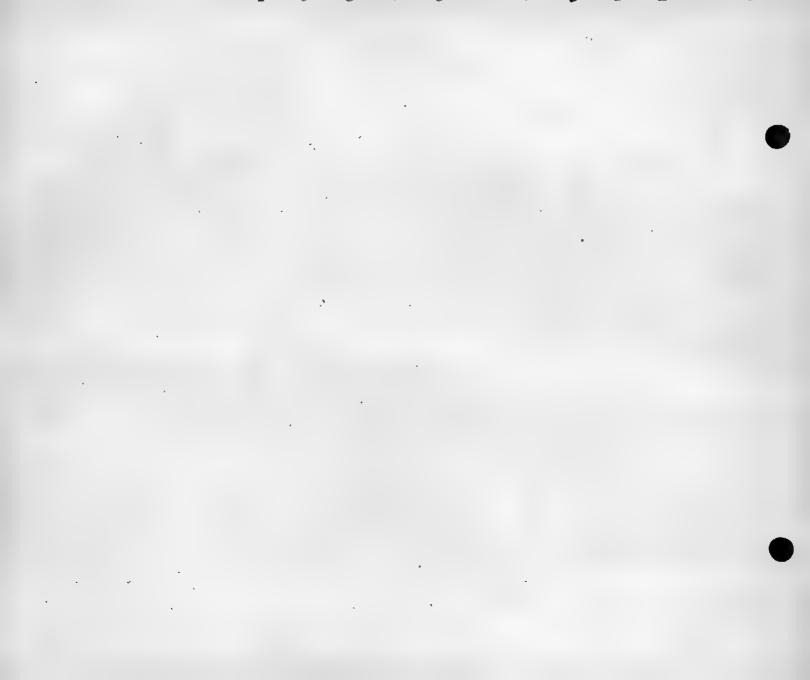
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11227 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death I. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before polyn swor o COUNTY o. STATE **b** COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR JOWN III outside corporate limits, write BURAL and give negrest town write-RURAL and give nearest town) ician and camptotely filled in by the lease remave carban papers. Pagand in any event, within 72 haurs d NAME OF HOSPITAL OR INSTITUTION (If not, in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? NAME OF Middle 4. DATE Yenr DECEASED **OF** (Type or pnnt) DEATH 19 6 IF UNDER 24 HRS S SEX . 6. COLOR OR/RACE DATE OF BIRTH 9. AGF (In yegrs IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED Months Doys Hours WIDOWED DIVORCED 100 USUAL OCCUPATION (Gwe kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stord, or foreign country) during most of working life, even stretared? INDUSTRY COUNTRY? attending physician termit. Then please Asst P.M. Aen S. Gov!t 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME or remayal, Bernard Kohrn Sheindel Sternlicht Modical Ex 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, no, or unknown) A(if yes give wonor dotes of service) burial, crematian, 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b) INTERVAL BETWEEN zond (c) signed by the burial-transit ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE (AUSF (o) DUE TO 11 - Mod-Necrotic Conditions, if ony, which gove rise to immediate couse (o), DUF TO stating the underlying couse as the attending be detached for use as the State Dept. of Health priar to lost. 19. WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) NO YES the haspital or certificate 20p ACCIDENT WAS UNDERLYING [7] 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAM, NER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour o.m. foctory, street, office bldg., etc.) Not While ot work of work 21. I certify that (I) (this haspital) attended the deceased from to XPage 4 may be retained , and that death occurred at 99 DIRECTOR: saw the deceased alive on. 196 M, fram couses and an the date stated above 220 SIGNATURES 22b. DATE SIGNED **ATTENDING** M.D DIRECTOR PHYS 22c. PHYSICIAN'S 22d. TO FUNERAL NAME (Type) Robert Kramer, M.D. 23b DATE THEREOF 23d LOCATION (City or Town) 230. BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY (County) (Stote) REMOVAL (Specify)
Burial 8-28-1967 Falls Church National Memorial Park Va. 25b. REGISTRAR S SENATURE 24. FUNERAL DIRECTOR 2So. REC'D BY REGISTRAR VR A15 (4) 156/ 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the deoth certificate be executed within 24 hours after death. funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY b. COUNTY CNTGOMERIL MARYLAND MONTGEMERE Pages the b CITY OR TOWN (If outs de corporate fimits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (If fortside corporate limits, write RURAL and give negrest town) completely filled in b nove corbern appers. ny event, within 2 ho d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give, freet address) d. STREET ADDRESS IS RES DENCE ON A FARM? 0000 NO F NAME OF DATE Last Month Year DECEASED (Type or print) 19 DEATH cremation, or remaval, and in ony everi 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years IF JNDER 1 YEAR IF UNDER 2441RS remove lost birthdoy) WIDOWED DIVORCED Unknown physician and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT please Kestaur AN during most of working life, even if retired) COUNTRY? of cece KESTGURANT CWHER 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME signed by the ottending phy buriol-transit permit. Then Unknown Unknown 10009 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service): Grayson Avenue 1B. CAUSE OF DEATH (Enter only one couse per line for (q), (b), and (c).) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: ONSET AND DEATH Cul IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital ar ottending physicion. DHE TO buriol, a Conditions, if any, which gove rise to immediate cause (a), DUE TO stating the underlying couse DIRECTOR: After this certificate has been as the State Dept. of Health prior to 19. WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) for use arlertosc erosis: NO OR ATTENDING PHYSICIAN: 20o ACC, DENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c TIME OF INJURY Month, Day, Year (City or fown) (County) (Stote) Hour o.m. foctory, street, office bldg . etc \ While Not While at work pe 21. 1 certify that (I) (this hospital) attended the deceased from director, page 3 should should be filed with the , and that death accurred at 23± PM, fram causes and an the date stated above 1967 saw the deceased alive an 22o, SIGNATURE 22b DATE SEGNED ATTENDING STAFF PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type 230 BURIAL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (Stote) REMOVAL (Specify) Crematory remation GEOTGES tince 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67

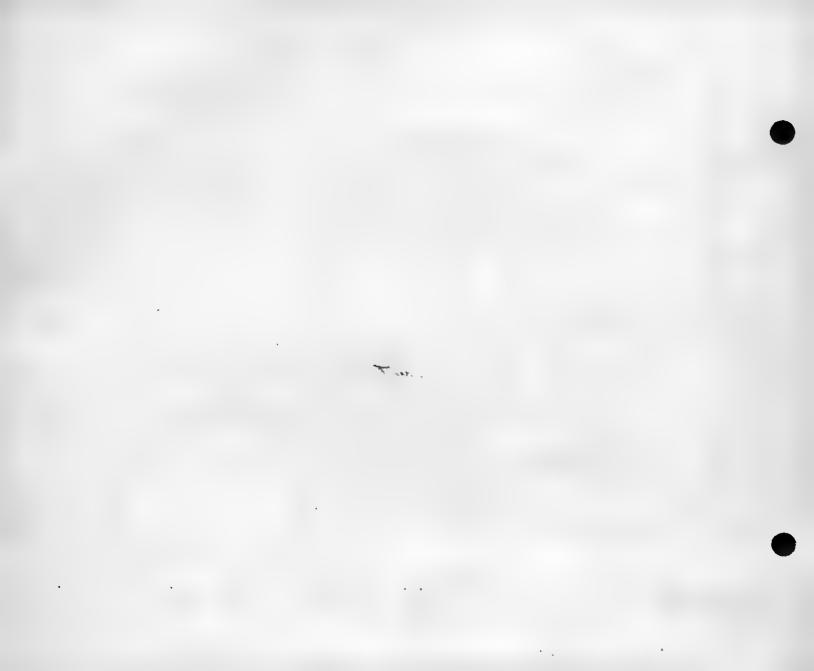


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. 1. PLACE DF DEATH 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. COUNTY b. COUNTY > a. STATE after MARYLAND b. CITY DR TOWN (if outside corporate limits, c. LENGTH OF STAY IN 1b c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town write RURAL and give hearest fown) 12 PM Drem d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, gite street address e. IS RESIDENCE ON A FARM? O STREET ACORESS 24 within ND JP YES within NAME DE First Middle Month Oay DECEASED DF event (Type or print) ÖEATH = orage 19 executed AGE (In Wars | FUNDER 1 YEAR | FUNDER 24 HRS | Jast birthday) Months | Days | Hours | Min. SEX 6. COLOR OR RACE 8. DATE OF BIRTH remove 7. MARRIED NEVER MARRIED and WIDDWED X **OIVORCED** 1Da. USUAL OCCUPATION (Give kind of work done) Ξ 10b. KIND OF BUSINESS OR CITIZEN OF WHAT (County & State, or foreign country) 12. sician lease and ir þe during most of working life, even if retired) INDUSTRY ling physi Then ple death certificate removal. FATHER'S NAME MOTHER'S MAIDEN NAME attendi 15. WAS DECEASED EVER IN U.S. ARMED FORCES 16. SDCIAL SECURITY ND. 17. INFORMANT Address l-transit permit. (Yes, no, or unkown) | (If yes give war or dates of service) 10/50m 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), INTERVAL BETWEEN The faw requires that the ONSET AND DEATH 3 PART I, DEATH WAS CAUSED BY the hospital or attending physician. been signed the burial-train or to burial, cri IMMEDIATE CAUSE (a) DUE TO Conditions, If any, which gave rise to immediate DUE TD cause (a), stating the underlying cause last. 83 CERTIFICATION PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY 19. for use Health PERFORMEO? certificate ND [20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) PHYSICIAN: 2Db. DESCRIBE HDW INJURY DCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) r this cert detached (State) 20c. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 120e. PLACE OF INJURY (Home, farm, (County) 2Df. (City or town) factory, street, office bldg., etc.) Hour a.m. After Id be d Not While While at work p.m. 19 at work 3 should with the 21. I certify that (I) (this hospital) attended the deceased from DIRECTOR: and that death occurred at saw the deceased alive on M, from the causes and on the date stated above. SIGNATURE 22b. DATE SIGNED 22a. page ATTENDING M.O. PHYS DIRECTOR PHYS Page 4 may HOSPITAL FUNERAL 22c. PHYSICIAN'S 22d. ADDRESS TO FUNERA director, should NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, tewn or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) 62017 イブノマ REC'O BY REGISTRAB RÉGISTRAR'S SIGNATURE **FUNERAL DIRECTOR** A15 (4)



	Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
- ~(M	11228 CERTIFICATE OF DEATH	3.0
death ond death	1. PLACE OF DEATH a. COUNTY 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before ad o. STATE b. COUNTY	,
within 24 hours after deat sly filled in by the funerol pon papers. Pages 1 and within 72 hours after deat	b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Silvey Sering Montgomery MARYLAND C LENGTH OF STAY IN 1b C CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) Silvey Sering	
hour in by rs. P	d NAME OF HOSPITA. OR INSTITUTION/(If not in hospital, give street oddress) d. STREET ADDRESS e. IS	RESIDENCE
in 24 illed pape pape hin 77	Holy Cross Hospiral 531 Drent Kd VIS	
completely filled over carbon pape	3 NAME OF DECEASED (Type or print) MARGARET Kathleen LAVIN DEATH BODY	Year 1967
be executed within n ond completely fill se remove carbon p of in ony ment, within		UNDER 24 HRS.
ate be e ician ond lease rei ond in o	100 USDAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR III. BIRTHPLACE (County & State, or fareign country) 11. BIRTHPLACE (County & State, or fareign country) COUNTRY?	IAT
ertificate be physician on nen please noval, and ii	13. FATHER'S NAME JAMES Anthony Lavin Margaret Catherine Tyre	Re II
at the death cer the ottending parit permit. The mation, or remo	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dates of service) 16 SOCIAL SECURITY NO 17. INFORMANY Father Address ec 3 above	
PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, he hospital or attending physicion. The hospital or attending physicion on completely filled in by the funeral his certificate has been signed by the ottending physician and completely filled in by the funeral stacked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 Dept. of Health prior to burial, cremation, or removal, and it only ment, within 72 hours after deptring the prior to burial, cremation, or removal, and it only ment.	18 CAUSE OF DEATH (Enter only one cause per time for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions of any which cause	AL BETWEEN AND DEATH
O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Poge 4 may be retained by the hospital or attending physicion. D FUNERAL DIRECTOR: After this certificate has been signed by director, page 3 should be detached for use as the burial-tron should be filed with the State Dept. of Health prior to burial, crer	rise to immediate cause (a), stating the underlying couse (c) (c)	
idn: The law re-		S AUTOPSY RFORMED? NO
spitol certifical for for the for	PER YES 20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c TIME OF INJURY Manth, Day, Year Hour or m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form factory, street, office bidg., etc.) (Caunty)	
TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Poge 4 may be retained by the hospital or attending to FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	20k TIME OF INJURY Manth, Day, Year Haur a m. p.m. 19 20d INJURY OCCURRED While at work of wor	(State)
NDING by After d be d be le Stot	21. I certify that (I) (this-hospital) attended the deceased fram 8-27, 1962, ta 530, 1962, that	(I) (we) las
O HOSPITAL OR ATTENDING Poge 4 moy be retained by the D FUNERAL DIRECTOR: After a director, poge 3 should be d should be filed with the State	saw the deceased alive an 1967, and that death accurred of 5:457 M, fram causes and an the date s 220. SIGNATURE) ATTENDING MED STAFF 226. DATE SIGNED	rarea abave.
L OR report of the property of	22c PHYSICIAN S/ 22d. ADDRESS	2
SPITA 4 mo 1 mo or, po d be	NAME (TypeY Raymond Gibbons, M.D. 2401 Blueridge Ave., Wheaton, Md.	
TO HOSPITAL Poge 4 moy O FUNERAL director, pog should be fil	230 BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) REMOVAL (Specify) Destantes 5.1967 M + Olivet	(State)
VR A15 (4) 20 M 1/66	24. FUNERAL DIRECTOR 250. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE JOHNES T. Ryon 317 Paris Sep. S. E. DATE SEP 6 1967 Filiables y	udges
Mr. A		

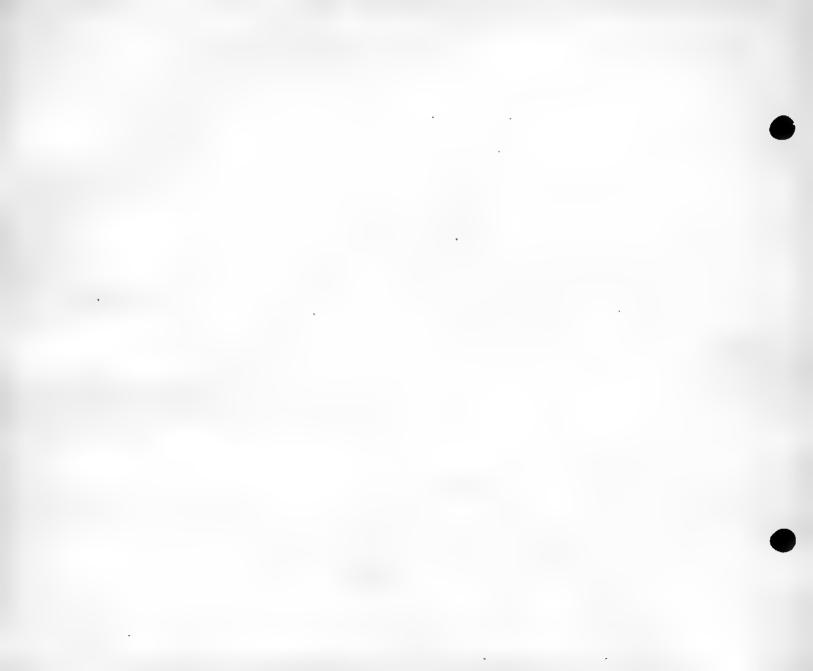
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11231 11230CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death funerol 1 ond ond PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o STATE **b** COUNTY filled in by the fune in papers. Pages 1 o ithin 72 hours after d MARYLAND c LENGTH OF STAY IN 16 b CITY OR TOWN (If autside carparate limits, c. CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) write RURAL and give negrest to wat e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS NO 🔀 DATE carbon 3 NAME OF Middle Year DECEASED (Type or pont) DEATH AGE (In year) IF UNDER YEAR F UNDER 24 HRS S SEX 6. COLOR OR RACE 7 MARRIED X NEVER MARRIED 8. DATE OF BIRTH 2 Months rthday Days Hours à WIDOWED DIVORCED 12 CITIZEN OF WHAT 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1) BIRTHPLACE (County & State or foreign country) during most of working the even it intered) INDUSTRY INDUSTRY COUNTRY UJSIA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAMI or remova GROSOARD 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 3 Ge. Coucourse (Yes, na for Inknown) (If yes give wor or dates at service) signed by the atter buriol-tronsit perm burios, cremation, o INTERVAL BETWEEN ONSET AND DEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY Thrombosis IMMEDIATE CAUSE (o) DUF TO undateurn Atheroscienosis Generalized Conditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying cause os the PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS PERFORMED? for use PNCHOC NO 🔀 20b DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I ar Part II of item 18) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (State) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, form (City or town) (County) 20c TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc.) Hour o.m. Nat While at work TO FUNERAL DIRECTOR: After 21 I certify that (1) (this hospital) attended the deceased from June 15 19 67, that (1) (we) las 1965 to Aug M, from causes and on the date stated above 1967, and that deoth occurred at saw the deceased alive an 22o. SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v M.D. TO HOSPITAL 1 Page 4 may b 22d ADDRESS 22c PHYSICIAN'S 8218 M. D. WISCONSIN NAME (Type) 23c NAME OF CEMETERY OR CREMATORS 23d_ LOCATION (City or Town) 230 BURIAL, CREMATION (County) 250 REC'D BY REGISTRAR DATE AUG 2 2 25b REGISTRAR'S SIGNATURI FUNERAL DIRECTOR VR A15 (4) 25M 1/67

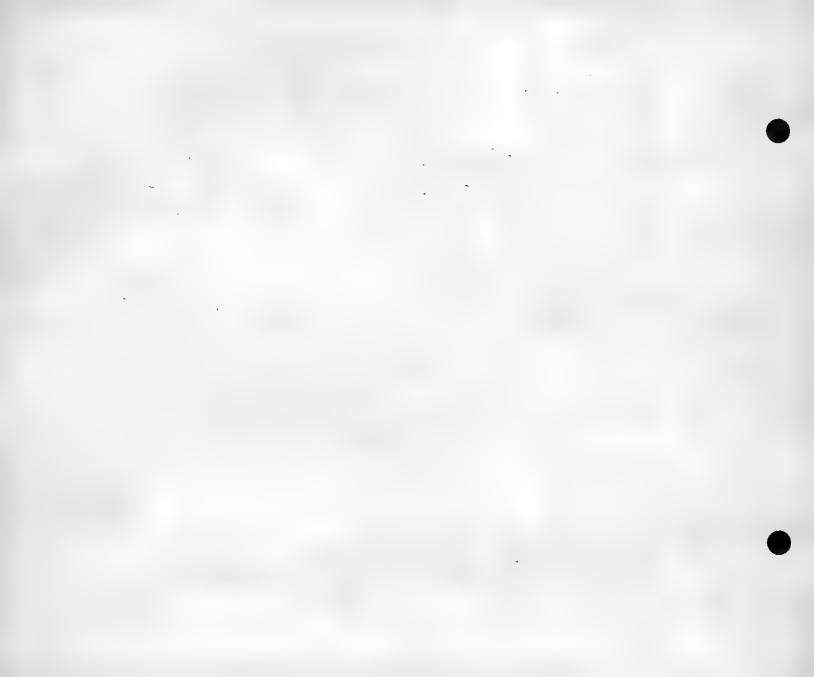


	It	ems 18-21 Film 391 & MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE		11231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11232
th. If way delay is H form PM3. Page L before delay is H form PM3. Page L before delay is H for a feet delay i	7	DISTANCE OF DEATH O SOCIONE MARYLAND MARYLAND D STATE OF DEATH O SOCIONE MARYLAND MARYLAND MARYLAND MARYLAND D STATE OF DEATH D STATE OF MARYLAND D STATE OF MARYLAND D STATE OF DEATH D STATE OF MARYLAND D STATE OF DEATH D STATE OF MARYLAND D STATE OF MARYLAND D STATE OF DEATH D STATE OF MARYLAND D STATE OF MARYL
MINER: This certificate should be executed within 24 hours after death. If the certificate, writing the word "pending" in pencil in Item 18. Give Pages 14 should be forworded to the Chief Medical Examiner's Office along with farm rilles. By Should be used as a burial-transit permit File pages 1 and 2 with the State Deant, prior to burial, cremation, or removal, and in any event within 72 hours	S 10 du	DECEASED (Type or print) Teoriard to Sale demback St. DEATH SEX 6 (DLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (n yeors lost birthday) WIDOWED DIVORCED 4-10-24 PR North St. Days Hours Min Days Hours Min Occupation (G ve kind of work done ring most of working life, even if retired) FATHER'S NAME 14 MOTHER'S MAIDEN NAME
ecuted with mg" in perdical Exardical Exargination of the sound, and	15	WAS DECEASED EVER IN U.S. ARMED FORCES? BY AND DECEASED EVER IN U.S. ARMED FORCES? BY AND SURFACE SURGES 17 INFORMANT BY Address Wary 9. Leimbach Silver Spring Parkway Paryland
This certificate should be executed within cate, writing the word "pending" in pencil be forworded to the Chief Medical Examine be used as a burial-transit permit File pager to burial, cremation, or removal, and in a		18 CAUSE OF DEATH (Enter only one couse per ne for (a), (b), and (c).] PART DEATH WAS CAUSED BY Gunshot wound in head with extensive OASET AND DEATH
his certifi ale, writin e forword be used o	MOIL	PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART I(0). 19 WAS AUTOPSY PARTORMED? YES 7 NO 1
INER: This is certificate, should be figured. 3 should be first. 3 should be ent, prior to	IL CERTIFICATION	20b DESCR BE HOW NJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of term 18) PRIMARY DE OF CONTRIBUTING □ CAUSE OF DEATH 20b DESCR BE HOW NJURY OCCURRED (Enter noture of injury in Port 1 or Port 11 of term 18) Deceased shot self in mouth with pistol
EXAMINER: ute the cert oge 4 should your files. Poge 3 shou	MEDICAL	2Dt TME OF INJURY Month Doy, Year 2Dd IN.JRY OCCURRED 2De PLACE OF INJURY (Home, form, factor), Street office bldg, etc.) 20f (City or town) (County) (State) 2De PLACE OF INJURY (Home, form, factor), Street office bldg, etc.) Silver Spring Mont; Md
ose execured for a sign of the		21. I certify that thook charge of the remains described above, held an Autapsy Inspection Inquiry and in my apinion death resulted from Natural causes Accident Suicide Inquiry Accident Acciden
ro DEPUTY M necessory, ple the funerol di 5 may be ret o FUNERAL D Health or its		EXAMINER'S NAME (Type) 3ELDEN COUNTY) COUNTY) COUNTY) COUNTY) COUNTY)
TO DE SERVE LA PERIOR HEAL	23	o BUR AL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETRY OR CREMATORY 23d. LOCATION (City or Topy) (County) (Store) Burial (Specify) Ang 7, 1967 Cedar Hill Cemetery Suitland, Maryland
VR A15ME (5)	19	Affinere Director as The State



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE 11233 HEALTH, DEPT. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) COUNTY STATE **b** COUNTY the State Department af MARYLAND OR TOWN (If outside corporate I m) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest town) write RURAL and give peerest town 010 d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street oddress) d. STREET ADDRESS e IS RESIDENCE alang with farm ON A FARM? in Item 18.-Give Pages NO Z NAME OF First Middle Lost DATE Year DECEASED (Type or pnnt) DEATH 19 pages I and Nwith S. SEX AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE MARRIED DATE OF BIRTH ost birthday) Months Hours event within 72 haurs after death. WIDOWED DIVORCED farwarded to the Chief Medical Examiner's Office 10o. USUAL OCCUPATION (Give kind of work done (State or foreign country) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR during most of working life, even if retired) a COUNTRY? INDUSTRY This certificate should be executed within 24 Pharmacis 13. FATHER S NAME MOTHER'S MAIDEN NAME File Or 16. SOCIAL SECURITY NO 15 WAS DECEASED EVER ING S ARMED FORCES? INFORMANT Address (Yes, no. of unknown) (If yes give wor or dotes of service) CAUSE OF DEATH (Enter only one couse per line-for (o), (b), one (c) INTERVAL BETWEEN burial-transit PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o) writing the ward DUE TO and in any Conditions, if ony, which gove (b) rise to immediate cause (a). DIJE TO stoting the underlying couse lost. 19 WAS AUTOPS)
PERFORMED? PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) removel, CERTIFICATION please execute the certificate, NO YES 20a EXTERNAL CAUSE WAS 20b DESCRIBE HOW IN. JRY OCCURRED (Enter noture of mory in Port L or Port L of Item 18.) 3 shauld PRIMARY Or CONTRIBUTING 4 should Ö CAUSE OF DEATH crematian, 3 20c. TIME OF INJJRY Month, Dov. Year 20d INJURY OCCURRED 2Ge PLACE OF INJURY (Home, form (City or town) (County) MED YOUR Hour o.m. factory, street, affice blda., etc.) Not While FUNERAL DIRECTOR: Page of work ot work 21. I certify that I took charge of the remains described above; held on Autopsy [Inspection and in my opinion deoth resulted from: Notural couses Undetermined monner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAM NER prior SIGNATURE the funeral may Health fown or county 23d LOCATION (City of Yown) DATE THEREOF 0 KING DAVID MEMORIAL EARDEN 24 FUNERAL DIRECTOR
BERNARD DANZANSKY YSONS - WASHINGTON 2So REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATI VR A15ME (5) 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11233 CERTIFICATE OF DEATH 71234 requires that the deoth certificate be executed within 24 hours after deoth. 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. COUNTY MONTGOMERY o. STATE b. COUNTY VTRGTNTA MARYLANO c LENGTH DE STAY IN 15 CITY DR TDWN (If autside corporate limits, write RURAL and give nearest town) c CITY DR TOWN (If outside carporate limits, write RURAL and give nearest town) 79 days STERLING completely filled in d. NAME DF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? · NAVAL HOSPITAL 206 FIR COURT YES NO [Fil NAME OF First Lost DATE Month Onv Year corbon DECEASED (Type or pnnt) ROBERT NORMEN **LEWIS** AUGUST DEATH IF UN OER 1 YEAR S SEX 8. OATE OF BIRTH AGE (In years IF UNDER 6. COLOR OR RACE 7. MARRIEO **NEVER MARRIEO** Months last birthdov) 0oys Hours 15 MAY 1941 WIDDWED DIVORCED MALE CAUC and 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INCUSTRY COUNTRY? Union Co. New Jerseu MILITARY USA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremotion, or removal, NORMAN LEWIS MARTAN HOLLY 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dotes of service) YES 225-52-9712 SANDRA L. LEWIS. 206 FTR COURT SUBRITING INTERVAL BETWEE 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) ONSET AND DEATH tronsit PART I. DEATH WAS CAUSED BY: HODGKINS DISEASE IMMEDIATE CAUSE (o) by the hospital or attending physician. DUE TO signed the burial-treburial, a Conditions, if any, which gove rise to immediate couse (a). DUE TO os the prior to b stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPSY PERFORMEO? be detached for use State Dept. of Health YES X NO certificote 20b. OFSCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of item 18) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF CEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c. TIME OF INJURY Month, Ooy, Year Not While foctory, street, office bldg , etc.) ot work 21. I certify that (1) (this haspital) attended the acceased fram 22 MAY , 1967 , td.9 AUGUST , 1967 , that (I) (we) last Page 4 moy be retained saw the deceased alive an 10 AICTIST 1967, and that death accurred at 500 M, from causes and on the date stated above. DIMECTOR: 226 DATE SIGNEO 22o. SIGNATURE X DIRECTOR PHYS 19 AUGUST 1967 22d. ADDRESS 22c. PHYSICIAN'S IN RUNERAL NAME (Type) J. JOHNSON. MC. WAVAL HOSPITAL 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY DR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) ARLINGTON NATIONAL ARLINGTON 25o, RECO BY REGISTRAR 255 REGISTRAR 5 5 GNAT 24. FUNERAL DIRECTOR 1967 ARLINGTON FUNERAL HOME. DATEAUG FATRFAX DR. 25M 1/67

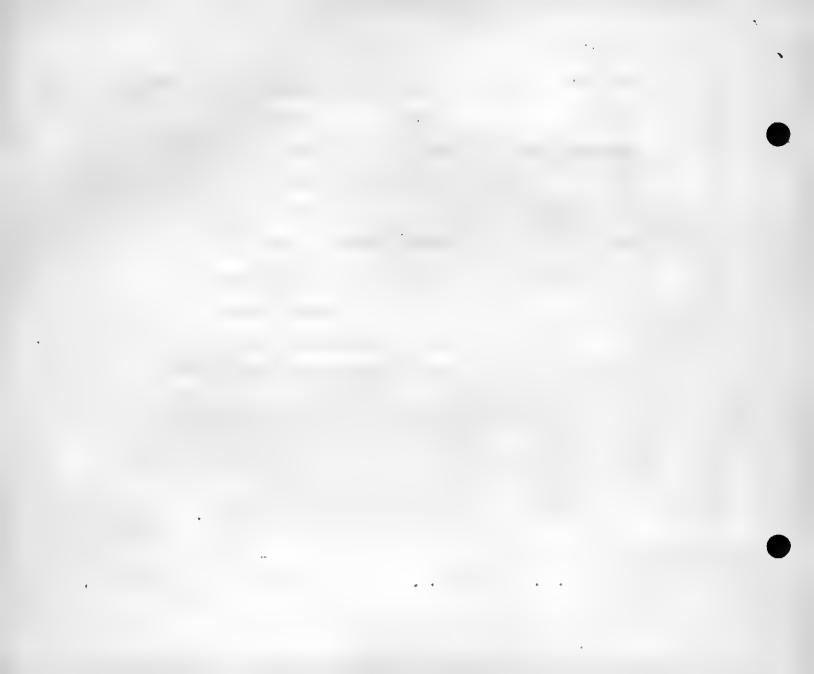


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11235 11234 CERTIFICATE OF DEATH and 2 death **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed, within 24 haurs after death funeral PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) "Montgomery o. STATE Maryland b. COUNTY signed by the attending physician and compretely filled in by the fur burial-transit permit. Then please reinage capban papers. Pages 1 burial, crematian, ar remaval, and in any event, within 72 hours after MARYLAND Montgomery b CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C LENGTH OF STAY IN 15 DÒA Olney Rockville d STREET ADDRESS English Manor d NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) e is residence on a farm? 14007 London Lane NO DE Montgomery General Hospital NAME OF Middle 4 DATE First Doy Year DECEASED OF DEATH Ioftus Thomas Joseph 28, 19 67 August (Type or print) IF UNDER I YEAR IF JNDER 24 HRS. 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7 MARRIED 30 **NEVER MARRIED** lost birthday) Months Doys Hours White 1/27/03 Male WIDOWED DIVORCED 10b KIND OF BUSINESS OR INDUSTRY GOV'T.
Printing Office 100 USJAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? Kansas USA 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Patrick Loftus Nellie Maher 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dates of service) 17 INFORMANT Address 16. SOCIAL SECURITY NO Medical Records yes INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
 PART I. DEATH WAS CAUSED BY: ONSET AND DEATH Acute myocardial infarction IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires thu Page 4 may be retained by the haspital ar attending physician 4201 DUE TO Conditions, if ony, which gove Arteriosclerotic cardiovascular disease rise to immediate cause (a), DUE TO ied far use as the b t af Health priar ta b stating the underlying cause has been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) CERTIFICATION NO IC certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury to Part I or Port II of item 18.) 20o ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached OF EITHER, NOTIFY MEDICAL EXAMINER director, page 3 shauld be detache shauld be filed with the State Dept MED CAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Dov. Year factory street, office bldg., etc.) Hour o.m. Not While ot work of work O FUNERAL DIRECTOR: After e deceased fram <u>January</u>, 19,60.pq<u>August 167</u>, that (I) (we) last 167, and that death accurred a<u>12-30</u>M, fram causes and an the date stated above. August 167, that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased from January saw the deceased alive an_ 22b DATE S GNED 220 SIGNATURE ATTENDING STAFF PHYS 8/28/67 M.D. DIRECTOR PHYS. 22d ADDRESS 22c PHYSICIAN'S NAME (Type) A. D. Bonifant, M.D. Medical Center, Sandy Spring, Maryland 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BURIAL CREMATION. Burial Specify) Parklawn Cemetery 9-1-67 Rockville, Maryland 250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR

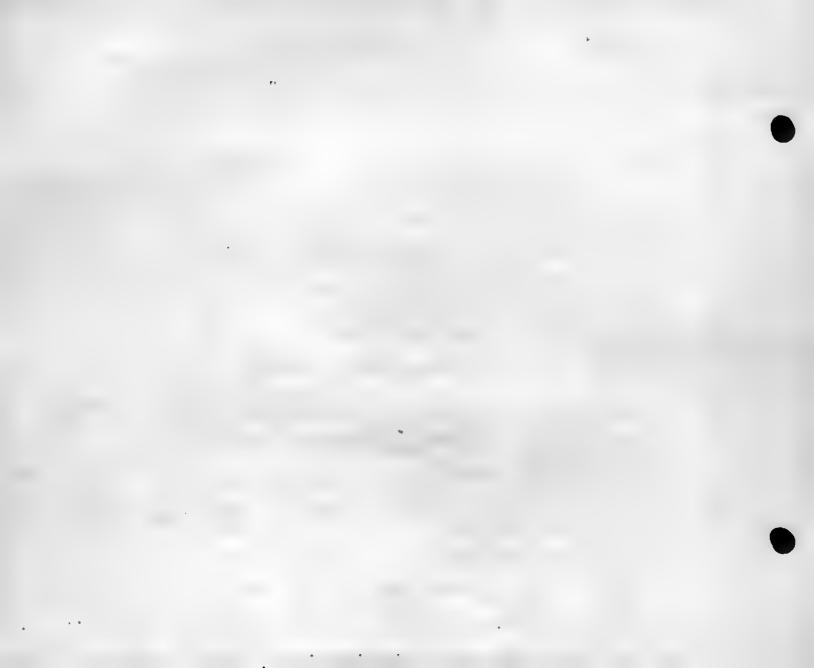
PUMPHREY. Bethesda. Maryland

ochanles Judge

VR A15 (4) 25M 1/67



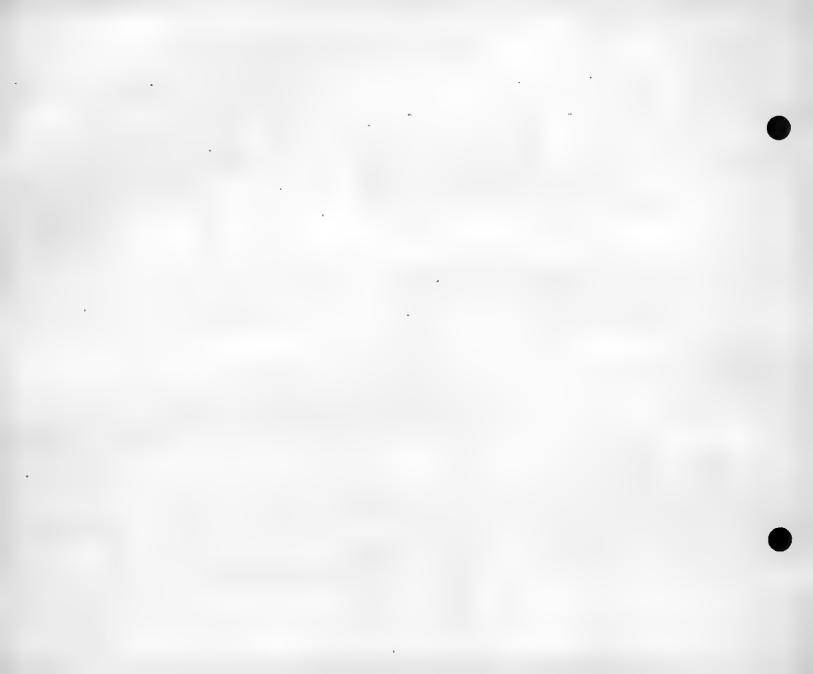
Division of STATISTICAL RE	MARYLAND STATE DEF SEARCH AND RECORDS, 301	PARIMENT OF HEALTH W. PRESTON STREET, BALTIMO	DRE, MARYLAND 21201	
11235	CERTIFICATE	OF DEATH	1123	6
1 PLACE OF DEATH o. COUNTY Monton mery founty	Maryland	2 USUAL RESIDENCE (Where deceased washington, D.C.	b. COUNTY	4
nonto mery County b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate S.E. (section)	imits, write RURAL and give nearest to	wn)
Wheaton d NAME OF MOSPITAL OR INSTITUTION (If not in hospit	1 da mks.	d. STREET ADDRESS	e. IS	RESIDENCE N A FARM?
University Nursing Ho		11 46th St., SE	YES	NO [
DECEASED (Type or print) lorence	Middle Eva Lucas	Lost 4. DATE OF DEATH	Month Doy 8/13/67	Year 19
S SEX 6 COLOR OR RACE 7, MARRI	The state of the s	DATE OF BIRTH 9. A		UNDER 24 H
during most of working life, even if retired)	b. KIND OF BUSINESS OR INDUSTRY	1) BIRTHPLACE (County & Stote, or foreign	COUNTRY?	AT
Char wo man 13. Father s Name		14 MOTHER'S MAIDEN NAME	2 UJM	
IVILLIA Bailey IS. WAS DECEASED EVER IN U.S. ARMED FORCES? [Yes, no, or unknown] [If yes give wor or dotes of service]	16. SOCIAL SECURITY NO. 17. IN	Katherine ?	Address	
no		la Green-11 46th		
18. CAUSE OF DEATH (Enter only one couse per line PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o)	COND & CVA			AL BETWEEN AND DEATH
Conditions, if ony, which gove) (b)	oldaze arten	o selevos iš		
rise to immediate couse (a), stating the underlying couse (c)				
PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTION	NG TO DEATH BUT NOT RELATED TO THE	HE TERMINAL DISEASE CONDITION GIVEN I	N PART I(o) 19. WA PER YES I	S AUTOPSY FORMED?
	DESCRIBE HOW MIJRY OCCURRED. (I	Enter noture of injury in Part I ar Part II		
20c TIME OF INJURY Month, Day, Year Hour o.m.	thile Net While focto	F OF INTURY (Home, form, 20f. (Construction)	ity or town) (County)	(Stote)
21. I certify that (I) (this haspital) at saw the deceased alive an		death acturred at 4:15 PM,	aug/3, 196), that	
220. SIGNATURE	And MD	ATTENDING MED.	STAFE 22b. DATE SIGNED	1967
22t. PHYSICIAN'S NAME(Type) Russell C. Bu	falino, M.D.		ilver Spring Md	
230 BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY OR C	REMATORY 23d. LOCA	10h (City or Town) (County)	(Stote)
BENOVA (Berly) 8/19/67	Lincoln Memo	250. REC'D BY REGISTRAR	2Sb. REGISTRAR'S SIGNATURE	Md.
	522 8th. St. S		1967 Jelianles &	noge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Ξ NO Z executed within completely 3. NAME OF Middle DECEASED all onins 196 (Type or print) 9. AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS last Alryhday) | Months | Days | Hours | Min. 5. SEX DATE OF BIRTH 6. COLOR OR RACE 7. MARRIED AT NEVER MARRIED remate WIDOWED DIVORCED 1 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT physician certificate be COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME removal 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (11 yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address 0 death tramit merm INTERVAL BETWEEN 18. CAUSE OF DEATH | Enter only one cause per line for (a), (b), and (c), ONSET AND DEATH signe by urial-trami PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) or attending physician. burial-tr burial, Conditions, if any, which peen gave rise to immediate DUE TO cause (a), stating the underlying cause last. CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY detached for use e Dept. of Health PERFORMED? NO I 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part | or Part |) of Item 18.) MEDICAL (State) 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED factory, street, office bldg., etc.) DIRECTOR: After tage 3 should be defilled with the State Hour a.m. Not While at work ___ at work 21. I certify that (I) (this hoopite) attended the deceased from saw the deceased alive on S P.M. from the causes and on the date stated above. and that death occurred at 22a. SIGNATURE 22b. director, page should be filed M.D. Page 4 may TO FUNERAL 22d. ADDRESS PHYSICIAN'S NAME (Type) BURIAL CREMATION, 23b. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) REMOVAL (Specify) 25a. REC'D BY REGISTRAR POST ADDRESS 24. FUNERAL DIRECTOR Hunterenn a Son VR A15 (4) 15M 4-64



-11 1	MARYLAND STATE DEPARTMENT OF HEALTH
	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
N 0 8 1	Montgomery MARYLAND STATE D. COUNTY Frince Georges
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PM3	Takona fark 6 days Adelph
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- E A	ON A FARM?
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ofter demth 3. G've Page along with with the Stot	DECEASED
o cer	(Type or print) Beth hone Lux Gord DEATH Qugust 12 1967 S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE (In year) IF JINDER 1 YEAR IF UNDER 24 HRS
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d d lice a	Temale White WIDOWED DIVORCED 9-30-65 IOST MINION PARTY OF MAINTENANCE (State or foreign country) 10a JSUAL OCCUPAT ON (Give kind of work dane 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT
Tar dar d	during most of working life, even if retired) INDUSTRY COUNTRY?
er's	13. FATHER'S NAME 14. MOTHER'S MADEN NAME
This cert ficate whould be executed within 24 hams ofter demth 1 cate, writing the ward "punding" in pencil in Item 18. Give Pages be farwarded to the Chief Medical Examiner's Office along with far be used as a burial-transit permit. File pages land 2 with the State remayal, and in any event within 72 hours ofter death.	Taxan Mark has a land
EX EX EX	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address
rted Fire sit.	(Yes, no, grunkngwn) lift ves give war ar dates af service)
eding eding erm	No none Hospital Record, Washington San. E
T W T	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY ONSET AND DEATH
Thie rons	IMMEDIATE CAUSE (a) Second and Third Degree Burns
varion va	DJE TO of 80% of Body Surface
buri ar	Conditions, if any, which gave (b) (b)
dir.	stating the underlying cause DUE TO
inting ande ande on	last (c)
cert , writh arware arware used aval,	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART 1(d) 19 WAS AUTOPSY PERFORMED?
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	200 EXTERNAL CAUSE WAS 20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part L or Part L of item 18) PRIMARY OF CONTRIBUTING TO THE PRIMARY OF T
EXAMINER: ute the certificate 4 should your fles. Page 3 shauld	
the state of the s	20c T ME OF INJURY Month Day, Year 20d INJURY OCCURRED 2De PLACE OF INJURY (Home forms as 8) 1 16th, of dwish mowning gnited.
Ecute the Page 4 or yaur R: Page 1, cremat	January Lat Nome Rectord 11. 0.00. 00., rate
At Executive Page 1971	21. I certify that I taak charge of the remains described above, held an Autapsy 📉 Inspection 💢 Inquiry 💢 and in my apinion
p ease execute d rectar Page reto ned for yau. DIRECTOR: Page re to bur a, crem	death resulted from: Natural causes , Accide X, Suicide , Hamicide , Undefermined manner
ne ease e a rectar est ned birectif	ACTUAL ACTUAL CHEF MEDICAL EXAMINER C
ITY NE TY, p ease e erol d rector be reto ned RAL DIRECT	SIGNATURE A COLL O MD ASSISTANT MEDICAL EXAMINER L
O DIFILITY INF. At EXAL necessory, p ease execute the funeral a rector Page 4 5 may be reto ned for yaur O FUNERAL DIRECTOR: Page Health priar to bur a, crema	EXAMINER'S DOWN DEPUTY AND CALL MAMINER 12 1012
DEPT Secsson That That EUNE	NAME (Type) BELDEN R. SETAP MICH, Adolp & Letter Location or country Cliff, 12, 1967
The The Theol	230 BORNATION, 23b DATE THEREOF 23c NAME OF CREMATORY 23d OCAT ON (City or Town) (County) (Store)
\	Cremation May 14 1960 Flancoln Crematon Colman Wang Colling
VR A 15ME (5'	
6M 1 67	F. gasch's Sons Hyattsville, Md DATE AUG 16 1967 Bleanley Judge
Y	



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission) ofter death MARYLAND CITY OR TOWN (If outside corporate limits c. LENGTH OF STAY IN 16 outside carparaty limits, write RURA, and give necrest taw ond ote Deportme IS RESIDENCE ON A FARM Office along with NAME OF DECEASED OF DEATH (Type or print . E Months Dovs Hours 12. CIZZEN OF WHAT poges 13. FATHER'S NAME MOTHER'S MAIDEN _ pub be executed removol AB. CAUSE OF DEATH (Enter only one couse per PART I. DEATH WAS CAUSED BY ENSET AND DEATH 5 IMMEDIATE CAUSE (a) certificate should word cremation, DUE TO Conditions, if only, which gove rise to immediate couse (a), stoting the underlying couse o lost PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED? ogent, prior to 20o. EXTERNAL CAUSE WAS 3 should PRIMARY Or CONTRIBUTING CAUSE OF DEATH AL EXAMINER: 20c TIME OF INJURY Month, Doy, Year PLACE OF INJURY (Home, form, moy be retoined for your FUNERAL DIRECTOR: Page factory_street_office.bldq..etc. 21. I certify that I taak charge of the remains described above, held an Autopsy Inspection X death resulted from: Natural couses Suicide 🔀 Undetermined monner ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER **SIGNATURE** O DEPUTY **EXAMINER'S** TO FUNE! BURIAL, CREMATION, 23b DATE THEREO 23c. NAME OF CEMPTERY OR CREMATORY 23d. LOCATION (City or Town) REMOVAL (Specify) Parklawn Rockville, Maryland Buria. Funeral Home-1331 Rockville REC'D BY REGISTRAR VR A15ME (5) Marley Judge DATEAUG Rockville, Maryland 6M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE UNTGUMER HAMILTO MARYLAND c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside comparate limits, write RURAL and give negrest town) e IS RESIDENCE ON A FARM? attending physician and completely filled in permit. Then please remove carban papers d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO IX NAME OF First DATE DECEASED OF (Type or print) DEATH vent AGE (In years F JNDER 24 HRS SEX 6. COLOR OR RACE 7 MARRIED Jast birthdoy) Months Dovs Hours WIDOWED DIVORCED or remayal, and in any 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? TOUS EWIF MOTHER'S MAIDEN NAME 13 FATHER'S NAME Marguerity Bauer INFORMANT WAS DECEASED EVER IN J.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address Colle (Yes, no, or unknown) (If yes give war or dates of service) burial-transit permit 74-48-3 burial cremation, INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY signed by (IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO far use as the t stating the underlying couse O FUNERAL DIRECTOR: After this certificate has been PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? NO M YES 🗀 205 DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part 1 or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) with the State Dept. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Hour o.m. foctory, street, office bldg., etc.) shauld be , 1967, that (I) (we) lost 21. I certify that (I) (this hospital) attended the deceased from 196 / 10 Clen 12 and that death accurred at 11.551M, from causes and on the date stoted above. saw the deceased alive on. 220 SIGNATURE 22b DATE SIGNED MED DIRECTOR ATTENDING director, page 3 shauld be filed v 22c PHYSICIAN'S 22d. ADDRESS NAME (Type) 23d. LOCATION (City or Town) 23e BURIAL CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) Cedar Hill Crematory CAMERYALMETER 8-14-67 Suitland Prince Geo Md ADDRESS 2So REC'D BY REGISTRAR Pumphrey 7557 Wisconsin Ave VR A15 (4) 20 M 1/66



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CEDTICICATE OF DEATH

11241

	١.	CERTIFICATE	OI DEATH
)		PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, f institution. Residence before admission)
	(· COUNTY MONTGOMETY MARYLAND	o STATE MA MURANDO B. COUNTY
	ī	b CITY OR TOWN (If outside corporate limits, C LENGTH OF STAY IN 16	c CITY OR TOWN (if outside corporate lignits, write RURAL and give nearest town)
		wide RUBAL and give negrest town)	Silver Shring
			d STREET ADDRESS e 15 RESIDENCE
Ì		Wask, Same Hosp.	1220 EIN. Hichway YES NO W
		NAME OF First / Middle DECEASED	Last 4 DATE Month Doy Year
		(Type or pnnt) / RV/NC / NHTK	OW// Z DEATH 170G, 19 1967
	5 5	1/-1 1 1/1 -4	DATE OF BIRTH 9. AGE (In years IF UNDER 14 HRS. Igst birthday) Months Doys Hours Min.
	100	M2 / WITH WIDOWED DIVORCED NO. JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR	11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT
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	13	FATHER'S NAME	14. MOTHER'S MAIDEN NAME
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	15	S WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INF	ORMANT Address
	{re:	res, no, or unknown) (If yes give war or dates at service)	VE Markowitz -1220 E.W. Harry
		1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	INTERVAL BUTWEEN
		PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GI Bleeding	V ONSET AND DEATH
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		(a) Conditions, if ony, which gove) (b) Lancreatic Ca.	1 cinama à metastases 4 mos.
		rise to immediate cause (a), stating the underlying cause DUE TO	· ·
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L	SATIC	Hejalic encophalopathy	YES NO E
	CERTIFICATION	200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (En	iter nature of injury in Port I or Port II of item 18.)
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		21. I certify that (I) (this haspital) attended the deceased fram	
		saw the deceased alive an 41 1962, and that d	
		220 SIGNATURES AND	ATTENDING DIRECTOR PHYS PHYS PHYS PHYS PHYS PHYS PHYS PHYS
		22c. PHYSICIAN'S NAME (Type) MARYIN SCHNEISER M. A	22d ADDRESS
	23e	30 BURIAL, CREMATION, 236 DATE THEREOF, 23c NAME OF CEMETERY OR CRE	EMATORY 23d LOCATION (City or Town) (County) (Stote)
	1	REMOVAL (Specify) / Burial - 8/19/67 Sharon Gara	den Cerry, Valhalla, NY.
	24	24. FUNERAL DIRECTOR B. Dangaisky Sous ADDRESS 3501-14	SETULE 250. REC'D BY REGISTRAR . 256 REGISTRAR'S SIGNATURE
		O O washed	OC. DATAUG 2 1 1961 Juna Juna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely ful director, page 3 shauld be detached for use as the burial-transit permit. Then please remove carbon should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with Page 4 may be retained by the haspital ar attending physician.

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VR A15 (4) 25M 1/67



]	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
. (M.)	11241 CERTIFICATE OF DEATH
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naurs after 1 by the fui 2. Pages 1 haurs after	b CITY OR TOWN (if outside carporate limits, write RORAL and give neorest town) write RORAL and give neorest fown) write RORAL and give neorest fown) d NAME OF HOSPITAL OR INSTITUTION (if not in Mospital, give aftest address) d NAME OF HOSPITAL OR INSTITUTION (if not in Mospital, give aftest address) d STREET ADDRESS d STREET ADDRESS
filled in papers.	Holig Cross Hosp 346-6vans Dr. YES NO E
ed with cancon	3. NAME OF DECEASED (Type or print) S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years of UNDER 1 YEAR IN UNDER 24 HRS.
and com	SEX 6 COLOR OR RACE 7 MARRIED 2 NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years last birthday) WIDOWED DIVORCED B. DATE OF BIRTH 9. AGE (In years last birthday) Months Doys Haurs Min 100 USUAL OCCUPATION (Give kind of work dane 100 KIND OF BUSINESS QR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT
ertificate be physician an nen please (c iaval, and in	during most of working life, eyen if retired) 1NDUSTRY Nash. Las Light 6. 14 MOTHERS MAIDEN NAME COUNTRY? U.S.A.
h certif ing phy Then remava	JAMES MARSHALL 15 WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address
ne death cer affending p permit. The	(Yes, no, ar unknown) (If yes give wor or dotes af service) DAISY M. MARShall - SAMP AS ITEM 18. CAUSE OF DEATH (Enter only one cause per line for 0), (b), and (d) INTERVA. BETWEEN
equires that the death certific physician. signed by the attending physi burial-transit permit. Then pl burial, crematian, or remaval,	18. CAUSE OF DEATH (Enter only one couse per line ford), (b), and (c) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO DUE TO INTERVA. BETWEEN ONSELAND DEATH
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law rapage 4 may be retained by the haspital ar attending TO FUNERAL DIRECTOR: After this certificate has been director, page 3 shauld be detached for use as the shauld be filed with the State Dept. af Health priar to	20c TIME OF INJURY Manth, Day, Year Hour a m. 19 20d INJURY OCCURRED While at wark at wark 19 20d INJURY (Hame, farm, factory, street, affice bldg, etc.) 20f. (City or tawn) (County) (State)
TTENDI ained b OR: Af-	21. I certify that (!) (this haspital) attended the deceased fram 7-3/, 1967, ta 3, 1967, that (!) (we) las saw the deceased alive on 8-2 1967, and that death accurred at 3, 1967, from causes and an the date stated above 220 SIGNATURE 22b. DAIE SIGNED
L OR AITENI be retained DIRECTOR: A gge 3 shauld iled with the	M. M. Partody M.D. ATTENDING MED DIRECTOR DIRECTOR PHYS DIRECTOR D
SPITAL 4 may VERAL Id be fil	NAME (Type) / TOSEPH W. PEABODY TR 1234 19 17. N.W., WASL D.C.
TO HOSPITAL Page 4 may TO FUNERAL director, pag shauld be fi	230 BURIA, CREMATION, READYAL (Specify) Aug-5-67 (eday Hill Cemetary Scritter Value of County) (State)
VR A15 (4)	24 FUNERAL DIRECTOR ADDRESS WASH DC 250 REGISTRAR 25b. REGISTRAR S SIGNATURE DATE ALIG 4 1987 ACCORDED SURGES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

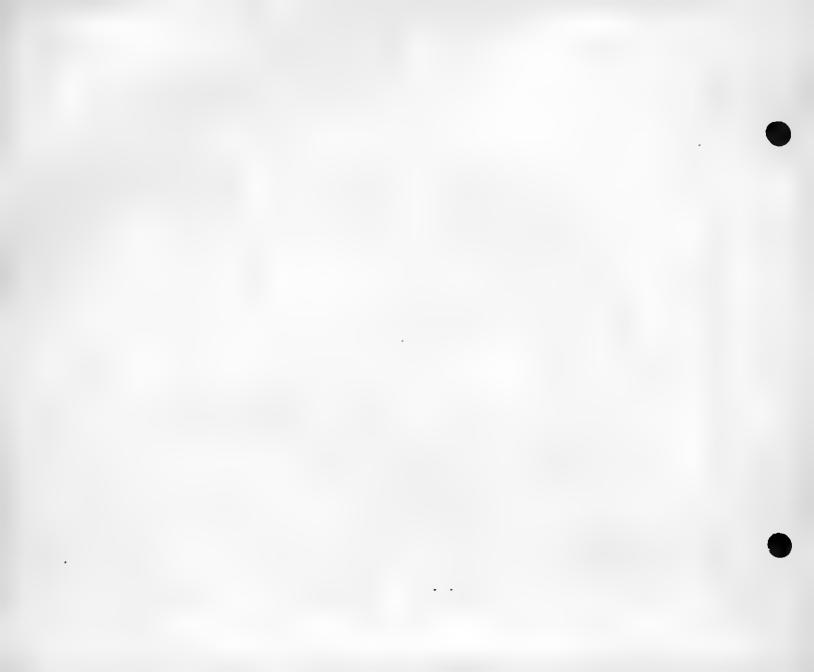
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•			DIVISIO	N OF STATISTI	CAL RESE			301 W. PRESTO		BALTIMORE	1, MARYL	AND
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	/		Silver	Spring		3 years 3	month	unkmst	o n			
led pers	ĺ		d. NAME OF HO	SPITAL OR INSTANTIO	N (if not in the	rospital, give street	address)	d. STREET ADDRESS			8.	ON A FARM?
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witter)	<u> </u>	3.	NAME DF DECEASED		rst	Middle		Last	4. DATE	Month	Day	Year
Fart a	- 1		(Typs or print)	MINNIE	= 6		/	Martin	DEATH	8	27	1967
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yal,		13.	FATHER'S NAM	IE .				14. MOTHER'S MAII	DEN NAME			
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tenc it.		15 (Yı	. WAS DECEASED	EVER IN U.S. ARMED FO (If yes give war or dates o	f service)	. SOCIAL SECURITY N		INFORMANT	0	Address	/8	elment,
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ed by the attending plansit permit. Then cremation, or remova		Ĭ		DEATH [Enter only on		line for (a), (b), and	(c).]			7	INTER	T AND DEATH
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			4000	DUE	TO	1)-	0	1- 11		12		
bur bur			Cenditions, if gave rise to		(b) G	reere	sch	oke fr	eery C	Kiskes	P 7	ears.
the see			cause (a), s	tating the DUE	TO	0 1 1	0	10000	4 . 0 -	0		10 411
has been sign as the burial prior to buria		z	underlying caus		(c)	ener		er cooc	ساس اساس	- Cens	RU(a) 159	WAS AUTOPSY
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of f		ERT	OR CONTRIBUT	WAS UNDERLYING ☐ ING ☐ CAUSE OF DEA	TH PDb.	DESCRIBE HOW 441	URY UÇÇUI	RRED. (Enter nature o	r injury in Part	or Part II or II	(eta 78.)	
offer this ce be detache State Dept.				TIFY MEDICAL EXAMI		MINION COOLINGED	Lone Di So	E OF HUNDYStone &	ann ODE (01)	w as tawa	(Caumbu)	(State)
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Star Star		ME	p.	m. 19	at wo	k at work					2 200	
S should with the			-	y that (I) (this hos	oital) attend					-27		at (II) we) last
いる。			sew the de	ceased alive on)	7	1967	and that	death occurred at	M, from		d on the date	
E S S			ZZa. SIGNATO	y W	8-7-	-67-04NG	1 200 6	ATTENDING	MED.	STAFF	Q ~ 2_	1-1:4
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Page 1	/		22c. HYSICY NAME (T	ype)				1 7 7	ONSVI	LE,	MID.	,
TO FUNERAL DIRE director, page 3 should be filed w	1	238	BURIAL, CREA		THEREOF	23c. NAME OF	CEMETERY			TION (City, town	or county)	(State)
5 A			REMOVAL (SD		-67	From	18	ale (Youts	reston	erg	med.
,	V	24	FUNERAL DIR	ECTOR /	1	ADDRESS	2	Marie 5a. RE	C'D BY REGISTR		STRAR'S SIGNA	TURE
AI5 (4)	W		Om	166 C	Tach	urot	colo	ECCO DATE!	SEP 1	1967	cores	Judge.
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11244 11243 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY Montgomery o. STATE b. COUNTY MARYLAND Pennsylvania b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate firmts, write RURAL and give nearest town) c. LENGTH OF STAY IN 1h 34 days Uniontown Bethesda d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) 200 1.2. d STREET ADDRESS IS RESIDENCE ON A FARM? The Clinical Center, Bethesda, Maryland 21 Pershing Court YES NO IX within 3. NAME OF DECEASED (Type or print) and campletely fi remave carbon First 4. DATE Month Year 1967 (None) Matthews August 31 James DEATH AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH 7 MARRIED NEVER MARRIED X lost birthdov) Months Dovs burial, cremation, ar remaval, and in any WIDOWED DIVORCED 25 January 1916 Male Negro 10o USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired)

Clerk 11 BIRTHPLACE (County & State, or foreign country) 10b, KIND OF BUSINESS OR 12 CITIZEN OF WHAT Pennsylvania Produce TISA 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME Mary Belle Gross Charles Matthews 15 WAS DECEASED EVER IN J S ARMED FORCES? 17. INFORMANTThe Medical Recordidatess 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dates of service) The Clinical Center, Bethesda, Maryland 178-07-0527 Yes INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY. signed by the burial-transit p ONSET AND DEATH Septicemia with peritonitis Davs IMMEDIATE CAUSE (o) TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that Page 4 may be retained by the hospital ar attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by **DUF TO** Conditions, if any, which gove 1 year Chronia glomerulonenhritis rise to immediate couse (a). DUF TO stoting the underlying couse as the prior tal Severe coronary arteriosclerosis vears 19 WAS AUTOPSY PERFORMED? PART 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES K Rheumatoid arthritis: lymphoma NO 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port i or Port II of item 18) 20p. ACCIDENT WAS JINDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. T.ME OF NSURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f. (City or town) (County) (Stote) foctory, street, office bldg., etc.) Not While of work of work 21. I certify that (1) (this haspital) attended the deceased fram 28 July 1967, to 31 August, 1967, that (1) (we) last saw the deceased alive an 31 August 1967, and that death accurred at 1:20 M, fram causes and an the date stated above director, page 3 shauld shauld be filed with the 22o. SIGNATURE 22b DATE SIGNED **ATTENDING** M.D. DIRECTOR PHYS. 1 Sent. 1967 22d. ADDRESS The Clinical Center, National 22c. PHYSICIAN'S NAME (Type) Institutes of Health. Daniel Ein. M.D. Bethesda . Md 230 BURIAL CREMATION, REMOVAL (Specify) NAME OF CEMETERY OR CREMATOR' 23d LOCATION (City or Town) (State) DATE THEREOF 2Sb. REGISTRAR'S SIGNATURE 250 REC'D BY REGISTRAR 24. FUMERAL DIRECTOR



1 1		EPARTMENT OF HEALTH	D 01001
19	Division of STATISTICAL RESEARCH AND RECORDS, 30		U 21201
= ~E		E OF DEATH	11245
funerol deat	PLACE OF DEATH G. COUNTY FROM GOMERY MARYLAND	2 USUAL RESIDENCE (Where deceosed lived, if institution R p. STATE Prince	Genraes
within 72 hours after death	b CITY OR TOWN (If outs de corporate l'mits, write RURAL end give negrest town) 4 months 8 da	c CATY OR TOWN (If outside corporate limits, write RURAL or Hyattsville	and give nearest town)
4 ho l in ers. 72 ho	d. NAME OF HOSP TAL OR INSTITUTION (If not in hospital, give street address)	d STREET ADDRESS	e IS RESIDENCE ON A FARM?
Filled paper him him	Holy Cross Hospital	6902 24th Avenue	AEZ NO
ed within 24 (letter filled eart, within 7	3 NAME OF First Middle DECEASED (Type or pnnt) Willard	Lost 4. DATE Month OF DEATH August	
complete com	5 SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED		UNDER I YEAR IF UNDER 24 HRS onths Doys Hours Min.
ertificate be ex physician and nen please rem naval, and in an	100. USUAL OCCUPATION (Give kind of work done down of the sum of t	11. BIRTHPLACE (County & Stote, or foreign country) Georgia	12. CITIZEN OF WHAT COUNTRY?
ficot ysici ple al, o	13. FATHER S NAME	14. MOTHER'S MAIDEN NAME	- Wat Jalla
certing bh	John J. Mauk	Mande Parmley	
death trendin srmit.]	(Yes, no, or unknown) (If yes, give war or dates of service)	INFORMANT 6902 24th Address erne M. Mank Hustaville	nue Maryland
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 has be retained by the hospital or ottending physicion. NIRECTOR: After this certificate has been signed by the ottending physician and comfleting filled in e. 3 should be detached for use as the buriof-transit permit. Then please remove carbon papers, ed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 has a with the state Dept of Health prior to burial.	IB. CAUSE OF DEATH (Enter on y one couse per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gove rise to immediate cause (a), stating the underlying cause lost. (c)	sit Melanoma	INTERVAL BETWEEN ONSET AND DEATH
r offer for offer for offer for lose os osth principal for	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)	19 WAS AUTOPSY PERFORMED? YES NO X
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NG PHY / the hc er this er this detocl	Hour o.m. While Not While of	ACE OF INJURY (Home, form, ctory, street, office bldg, etc.)	(County) (Stote)
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OR AT De reto DIRECTO Shree 3 shreed with		A.D. ATTENDING MED. STAFF DIRECTOR PHYS.	226. DATE SIGNED August 2, 1967
FITAL FRAL FRAL or, pag d be fil	22c. PHYSICIAN'S NAME (Type) Boris Rabkin, M. D.	1019 University Blud. E.	., S. S., Md.
TO KO Page To Fun direct	24. EUNERAL DIRECTOR ADDRESS	Cemetery Prince Georges 1 250, REC'D BY REGISTRAR 25b, REGISTRAR	RAR'S SIGNATURE
VR A15 (4) 1 20 M 1/66	Varner E. Pumphrey, Inc. Silver Spring.	ZSO. RECURS REGISTRAR 1967 PC	warles Juage



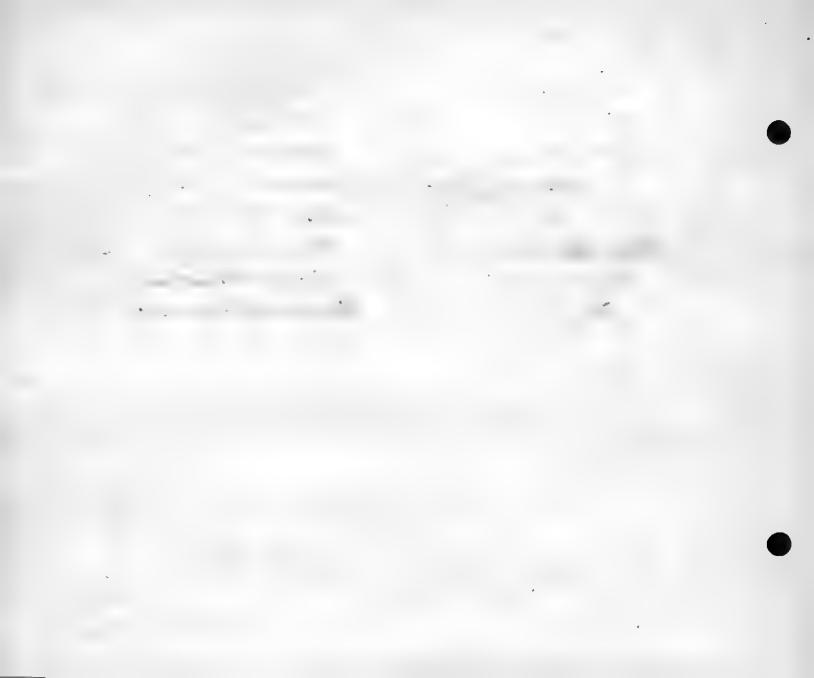
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) o. COUNTY ONTGOMERY MARYLANO b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIIVER SPRING MONTHS in by NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d. STREET ADDRESS ON A FARM? NAME OF 4. DATE Yeor campletely DECEASED UGENE AUGUST 19 (0 (Type or print) DEATH S. SEX AGE (In years IF UNDER 24 HRS 6. COLOR OR RACE birthdoy) WH DIVORCED 🔀 and in any 10b. KINO OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 1), BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
Data Processor COUNTRY? 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remava Helen M. Weir MC CARTY WILLIAM 16. SOCIAL SECURITY NO. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 611 Gilver Spring Ave. Silver Spring, Md. (Yes, no, or unknown) (If yes give wor or dotes of service Wm. J. Mc Carty 2/**X-**38-5993 TB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSEO BY.

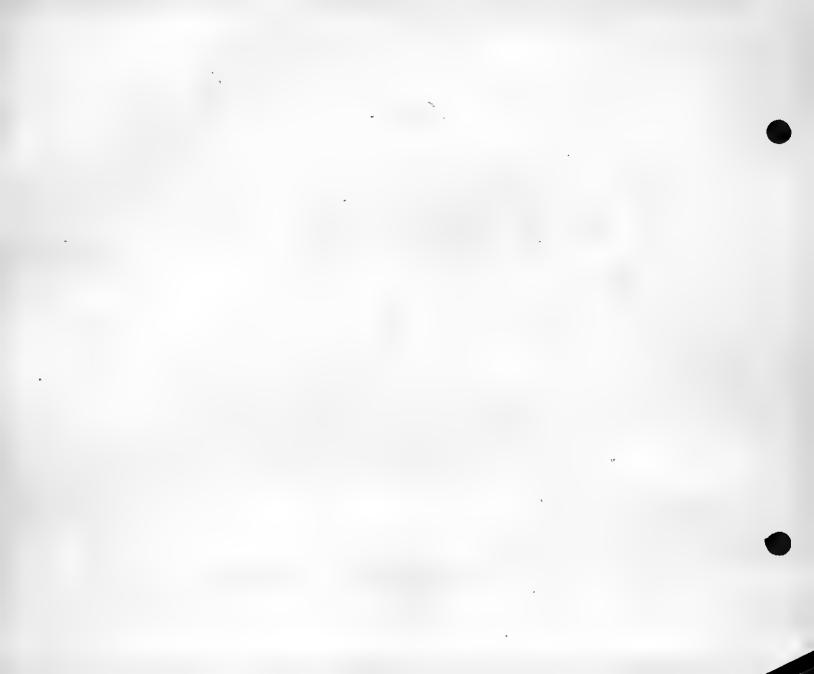
IMMEDIATE CAUSE (o) HODEKINS OUF TO burial, burial Conditions, if any, which gove (b) rise to immediate couse (a), **OUE TO** far use as the t Health priartat stoting the underlying couse WAS AUTOPS? PERFORMEO? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) YES [NO 20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port it or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF OF ATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) WEDICAL 20e PLACE OF INJURY (Home form. 20d INJURY OCCURRED (City or fown) (County) 20c. TIME OF IN. JRY Month, Ooy, Year Hour om. foctory, street, office bldg , etc.) 21. I certify that (I) (this haspital) be retained sow the deceased alive an TO FUNERAL DIRECTOR: , and that death accurred fram causes and ฮก 220. SIGNATURE M.D. DIRECTOR PHYS. director, page should be filed 22d ADDRESS 612 Main St., Laurel, Md. J. Richard Compton, M.D. NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BURIAL, CREMATION. 23b. DATE THEREOF REMOVAL (Specify) Silver Spring of Heaven Cemetery Funeral Home Silver Spring.



true //		MARYLAND STATE DEPARTMENT OF HEALTH	
		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE		fr 11246 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1268	
HEALTH DEPT.		PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission	1)
± \$ €. / 5		MARYLAND Maryland Maryland Montgomers	
ent e		b CITY OR TOWN (If outside corporate limits, write RURA and give neares flown)	
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5 % % % % % % % % % % % % % % % % % % %		m widowed Divorced May / 1895 72 yrs willing	PRI II
havrs Item 18 Office of 19422	100	SUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1 BIRTHPLACE (State or fare gn country) 12 CT ZEN OF WHAT COUNTRY?	
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within 24 pencil in xaminer's ile pages haurs aft	13	FATHER NAME 14 TO HERS MA DEN NAME	
within n pencil Examine File pag	-	James Mchonnell Ella Markanen	
executed withing and in pencil Medical Examin permit File page	1S (Ye	Address Social Security NO 17 INFORMANT Address Social Security NO 18 INFORMANT ADDRES	
xecuter Inding: Medical permit within 7			
be executed within 24 "pending" in pencil in net Medical Examiner's ons.t permit File pages I ent within 72 haurs afte		18. CAUSE OF DEATH (Enter on y one cause per line for (o), (b), and (c).) PART I DEATH WAS CAUSED BY ONE AND DE	ATH
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e sh the tat tat bur		rise to immediate couse (a).	
ficate ing ti rded as a and i		stating the underlying couse (c)	
		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBITING TO DEATH BUT NOT DELATED TO THE TERM NAIL DISEASE CONDITION CIVEN IN PART 1(a).	PŚY
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NER: T certifo hauld b iles. shaud on, ar ra	GR	PRIMARY 🖸 or CONTRIBUTING 🗇	
- a ~ - ~ :=	MEDICAL	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form 20f (City or town) (County) (S	itote)
₹ ቲ4 ≓ 9 å	A SE	Hour om. p.m 19 While of work	
L EXA ecute Page or you R: Pag		21. I certify that I took charge of the remains described above, held on Autopsy , Inspection , Inquiry XI, and in my a	pinton
2 X , 4 O .9		death resulted from: Natural couses X, Accident , Suicide , Homicide , Jindetermined manner	
MEDICA please e d rectar erained DIRECTO		CHIEF MEDICAL EXAMINER	
		SIGNATURE MD ASSISTANT MEDICAL EXAM NER 22. DATE S	IGNED
UTY / ary, pl neral o be re ERAL I prior		EXAMINER'S John G. Ball DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)	
TO DEPUTY necessary, p the funeral S may be n TO FUNERAL Health prior	00		4.3
Do the	730	BURAL (REMATON 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d 10CATON (City or Town) (Sterney Transit 8/8/67 Burlingame, California	116)
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VR A15ME (5) 6M 1/67	Гу	son Wheeler Funeral Home-1331 Rockville Pike AUG 9 1967 August 196	udge
WITH ST WE		Rockville, aryland	Y



4	MARYLAND STATE DEPARTMENT OF HEALTH	
Conflict to	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
HEALTH DERT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before ad	lmission)
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farm farm ate De	24 purban 17 11/13. Rd, VES	□ NO 🗸
24 hours after death If Gry dela in Item 18. Grve Pages 1, 2, and rs Office along with form PM3. Fest land 2 with the State Department after death	3 NAME OF DECEASED List Middle Cost 4 DATE Worth Doy	Year
Sive ng	(Type or print) / QUITA / OBEST / C CO GO DEATH / OF CO	UNDER 24 HRS
hours after Item 18. Give Office alang Iand 2 with the		ours Min
4 havrs Item 18 Office o Tand 2 v	100 JSUAL OCCUPATION (Give kind of work done 10b kind of 8051NESS OR 11 By THPLACE (State or foreign country) 12 CIT ZEN OE WH	HAT TAH
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s certificate should be executed within 24 e, writing the ward "pending" in pencil in farwarded to the Chief Medical Examiners sused as a bunar-transit permit. File pages noval, and in any event within 72 haurs after	DAOT I DESTRUDIES CAUSED BY	AL BETWEEN AND DEATH
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MELKA please ex d rector. d rector. To bur a	death resulted from Natural causes, Accident [X], Suicide, Hamicide, Undetermined manner	
dr dr dr to to to		DATE SIGNED
UTY, IIIY, Berra be price	EXAMINER'S DEPUTY MEDICAL EXAMINER & 8/16/67	
o DEPUTY MELKAL necessary, please exer the funera d rector. P 5 may be retained far 0 FUNERAL DIRECTOR. Health priar to bur al,	NAME (Type) JOHN G. ISALL Address (Street, cty, town, or county)	
The Head	230 BURIA. CREMATION. 23b. DATE THEREOF 23r NAME OF CEMETERY OR CREMATORY 23d .OCATION (City or Town) (County)	(Stote)
	24 HUNERA DIRECTOR GARTHER'S FUNERAL HOMEODRESS 316 E. Diamond 250 REF DAY REGISTRARY CT 250 REF 2	ordin .
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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	11243 CERTIFICATE OF DEATH
funeral 1 and 2 er death.	1. PLACE OF DEATH a. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE D. COUNTY MONTGOMERY MARYLAND
ding plysician. been signed by the attending physician and completely filled in by the fithe burial-transit permit. Then please remove canon papers. Pages 1 or to burial, cremation, or removal, and in any event, within 72 hours after	b. CITY OR TOWN (If outside corporate limits, write RURAL end give nearest town) write RURAL and give nearest town)
hours d in b rs. P.	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street eddress) d. STREET ADDRESS a. IS RESIDENCE ON A FARM?
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within pretely and pretely within	3. NAME OF First Middle Last 4. DATE Month Day Year
ompli vent	5. SEX 6. COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR) IF UNDER 24 MRS.
executed and compressions and some	Male Caucasion WIDOWED DIVORCED Jan. 4. 1909 58 yrs. Months Days Hours Min.
be en	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
ate l hysic plea al, an	Hotel Manager Presidential Hotel New Castle and U.S. A. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME
rtific ing p Then	Grank C. Michael Nina Brown
thendi	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) NO. 17. INFORMANT Address Kensington, Md.
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OR ATTENDING PHYSICIAN. The law requires that the death certificate be be retained by the hospital or attending plysician. IRECTOR: After this certificate has been signed by the attending physician et a shoulm be letalled for use as the burial-transit permit. Then please dwith the State Dept. of Health prior to burial, cremation, or removal, and it is the state of t	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death Sheet Square Course
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N: The law requited or attending tifficate has been for use as the fight that the fight of the f	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? YES NO OR CONTRIBUTING TO CAUSE OF DEATH OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
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PHY:	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) While at work at work at work
Affee by Stale	p.m. 19 at work at work 21. I certify that (I) (this hospital) attended the deceased from [20, 19, 19, 19, 19, 19, 19, 19, 19, 19, 19
taine thoul	saw the deceased alive on Will 2 19/2, and that death occurred at 3 MM, from the causes and on the date stated above
OR ATTENDING De retained by IRECTOR: After Se 3 shoull be of with the Sta	22a. SIGNATURE 22b. DATE SIGNED ATTENDING MED. STAFF
PITAL (4 may 1 may	22c. PHYSICIAN'S
OSPI.	NAME (Type) ROBERT T. THIBADEAU ROCKVILLE MT. 20852
TO HOSPITAL OR ATTENDING PHYSICIAN: The Jaw Page 4 may be retained by the hospital or aften to FUNERAL DIRECTOR. After this certificate has director, page 3 should be detailed for use as should be filed with the State Dept. of Health price the state of	29a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) REMOVAL (Specify) August 22, 1967 Cedar Hill Cemetery Suitland, Maryland
ar	24 FUNERAL DIRECTOR 250. REGISTRAR! SIGNATURE 250. REGISTRAR! SIGNATURE
VR A15 (4)	Warner E. Pumphrey Tuneral Home Silver Spring, Masu G 2 8 1967 floores June





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MONTGOMERY **b.** COUNTY MARYLAND b City OR TOWN (If autside corporate limits. c LENGTH OF STAY IN 15 c CITY OR TOWN (If autside corparate limits, write RURAL and give nearest tawn) write RURAL and give nearest Jouvn) D.O.A. d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENCE SANHARIUM YES NO NAME OF 4 DATE Day Year DECEASED OF DEATH MARIES (Type or pont) MES S SEX 7. MARRIED NEVER MARRIED last birthday) Months WIDOWED DIVORCED 1Da USUAL OCCUPATION (Give kind of work done 1Db. KIND OF BUSENESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State or fareign country) during mast of working life, even if retired) Wash.Terminal 13. FATHER'S NAME 14. MOTHER'S MAIDEN MAME Marie WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor ar dates of service) 719-03-171 18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c))
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if ony, which gove rise ta immediate cause (a). DUE TO stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(G) 19. WAS AUTOPSY PERFORMED? ron Chite NO TX 20a ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED/(Enter hature/of injury in Part I or Part II of item 18) OR CONTRIBUTING I CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER' 2Dc TIME OF INJURY Manth, Day, Year 20d INJURY OCCURRED 2De. PLACE OF INJURY (Home, farm (City or town) (County) (State) Not While factory, street, office bldg . etc.) 21 I certify that (1) (this haspital) attended the deceased from Man 1958 100 Cles . 19 6 / that (I) (we) last TO FUNERAL DIRECTOR: A director, page 3 should I should be filed with the S saw the deceased alive an 4 aug 1967, and that death occurred at 1/10, M, fram causes and an the date stated above 22n SIGNATURE 22b DATE SIGNED MED DIRECTOR 22c PHYSICIAN 22d. ADDRESS NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23d. LOCATION (City or Town) REMOVAL (Specify) Mt. Olivet Cometery 9/9/07 wash. D.C. S - uneral ADDRESS VR A15 (4) 25M 1/67 Hems Inc. Mar clanc



1 1	MARYLAND STATE DEPARTMENT OF HEALTH	
	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
FOR STATE		
HEALTH DEPT.	1. PLACE OF DEATH o. COUNTY b. COUNTY b. COUNTY	ssion
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id with in per Exam File p	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT Address Address	
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s certificate should be executed within 24 hours, writing the ward "pending" in pencil in Item 18 farworded to the Chief Medical Examiner's Office used as a burial-tronsit permit. File pages lond 2 vayol, and in any event within 72 hours after death	18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c) PART I DEATH WAS CAUSED BY.	BETWEEN O OFATH
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MINER: The certificates the should by tiles. The should by the states the sta	CAUSE OF DEATH Fall at home causing freeture of Pet light.	
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L EXAM lecute the Poge 4 or your R: Page		ny opinion
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ITY MEDICAL EXA ry, pleose execute erol director. Poge be retoined for you RAL DIRECTOR: Pog prior to burial, cren	ACTUAL CHIEF MEDICAL EXAMINER	ATE SIGNED
JTY ME Try, pleor erol director be retoil RAL DIR	SIGNATURE M.D. ASS STANT MEDICAL EXAM NER [Sugar 18, 1907	IE SIGNED
O DEPUTY MEDICAL EXAM necessory, please execute the funeral director. Page 45 may be retained for your o FUNERAL DIRECTOR: Page Hearth prior to burial, cremo	EXAMINER S NAME (Type) Address (Street, city, fown, or county)	4
TO DEPU necessor the func 5 may the Health g	230 BUR AT CREMATON, 23D DATE THEREOF 23C NAME OF CEMETERY OR CREMATORY 23d LOCAT ON (City or Town) (County)	(Stote)
- AN	BURIAL BECTOR STATE ADDRESS 250 REC BY REG STRAR 250 REG STRAR SIGNATURE	•
VR A15ME (5) (7)	Jos, GAWLER'S SONS, 5130 WIS, AVENW, WASH., D.C. DAUG 23 1967 gellanles Judge	c,
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/ 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11253 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 11854
HEALTH TEAT	THE PERSON OF TH
MEALTH DEAT.	1 PLACE OF DEATH O. COUNTY ALONT 9 CONECT 4. 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. STATE DESCRIPTION O. STATE
elay is id 3 to i. Page nent af death.	
	b CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Rethesda. C LENGTH OF STAY IN 1b C CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Bethesda. Was him 19 ton.
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hin 24 haurs ncil in Item I niner's Office pages I and 2 in any event	100 USUAL OCCUPATION (Give kind of work done done libb. KIND OF BUSINESS OR lib BiRTHPLACE (State or foreign country) 12 (ITIZEN OF WHAT COUNTRY?
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should be executer he ward "pending" ta the Chief Medical burral-tramsit permit matian, ar remaval,	18 CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).) WESTINGTONIES AND STREET OF THE CONTROL OF THE CAUSE OF THE C
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NER: certifu hauld lles. shaul t, prii	CAUSE OF DEATH
EXAMINER: Ti	20c. TIME OF INJURY Month, Doy, Year Hour o.m. 20d INJURY OCCURRED While Not While 100
	p.m. 17 of work C of work C
AI Parent	21 certify that I tack charge of the remains described above, held an Autapsy , Inspection , Inquiry , and in my opinion death resulted fram: Natural causes , Accident , Suicide , Hamicide , Undetermined manner
Ste ecto ecto ecto ecto ecto ecto ecto ec	CHIEF MEDICAL EXAMINER
MECALE) please execut please execut directar. Page retained for y LOIRECTOR 187 Its designated	ACTUAL SIGNATURE O. B. Ball - M.D. ASSISTANT MEDICAL EXAMINER () 22. DATE SIGNED
BRAIN O	EXAMINER'S DEPUTY MEDICAL EXAMINER 1 0/3/67
O DEPUTY MEETAL EX necessary, please execut the funeral directar. Page 5 may be retained for y 0 IUMIRAL DIRECTOR: P Hearth or its designated	NAME (Type) John G. Ball, M. D. Address (Street, city, town or county) 230 BURIAL (REMATION, 123b DATE THEREOF 123c NAME OF CEMETERY OR CREMATORY 123d LOCATION (City or Town) (County) (Stote)
10 TO I	230 BURIAL (CRMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) Rock Creek Cemetery Washington, DC
	24 FUNERAL DIRECTOR The S. H. Hines Co. ADDRESS 250 REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE
VR A15ME (5) 6M 1/66	Washington, D. C. DATE AUG 8 1957 Scharles Judge

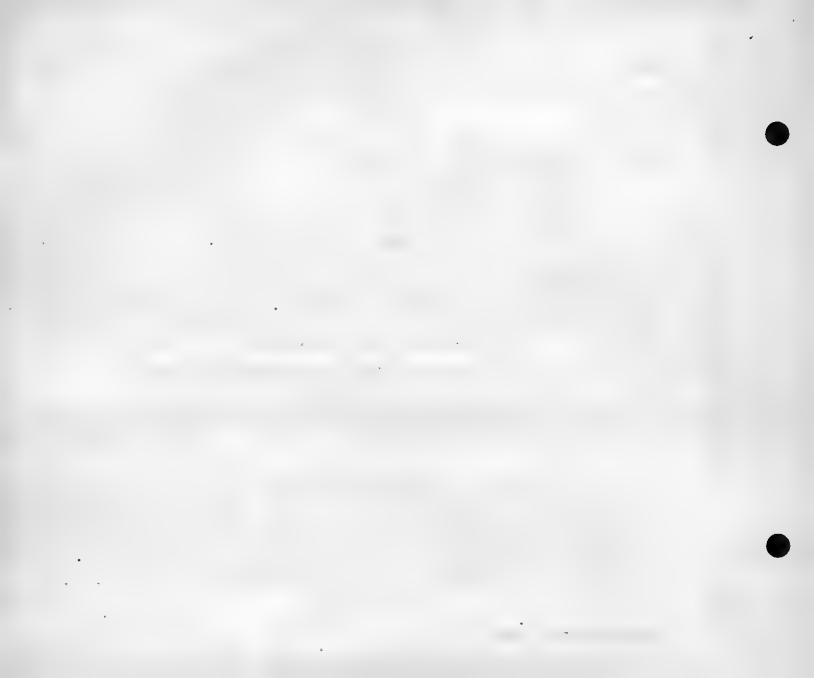
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1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND	
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phys phys n sign buria buria	nditions, if any, which (b) Vatural Causes.	
law requires that tatheding physician. I has been signed been as the burial-tranch prior to burial, cre	ise (a), stating the DUE TO derlying cause last.	
The law requires that the death certificate be executed within or attending physician. attending physician and completely use as the burial-transit permit. Then please remove carbon eafth prior to burial, cremation, or removal, and in any event, with	RTII. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTO PERFORMI	PSY ED?
PHYSICIAN: the hospital this certific detached for e Dept. of H	A. ACCIDENT WAS UNDERLYING COURTED. (Enter nature of injury in Part I or Part II of Item 18.) CONTRIBUTING CAUSE OF DEATH EITHER, NOTIFY MEDICAL EXAMINER)	-
	to TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.) p.m. 19 While Not While at work at work at work	te)
ATTENDING retained by CTOR: Affer should be vith the Stat	21. I certify that (I) (this hospital) attended the deceased from 1905, 19, to 19157, 19, that (I) (we	las
OR ATTENDIO De retained IRECTOR: A ge 3 should sed with the S	saw the deceased alive on 5 M W 19 and that death occurred at 5 M, from the causes and on the date stated a 22b. DATE SIGNED	Jove
TAL O may ball by page e filed	C. PHYSICIAN'S LOCALITY CONTROL M.D. ATTENDING MED. STAFF DIRECTOR PHYS. DIRECTOR D	r
O HOSPITAL Page 4 may O FUNERAL I director, pag	NAME (Type) \	- ر
To T Life	RIAL (Specify) 8/17/67 ARLINGTON NAT. CEM. ARLINGTON, VIRGINIA	7
VR A15 (4)	Sept Grawler's Sons I've Wash. Date Date	
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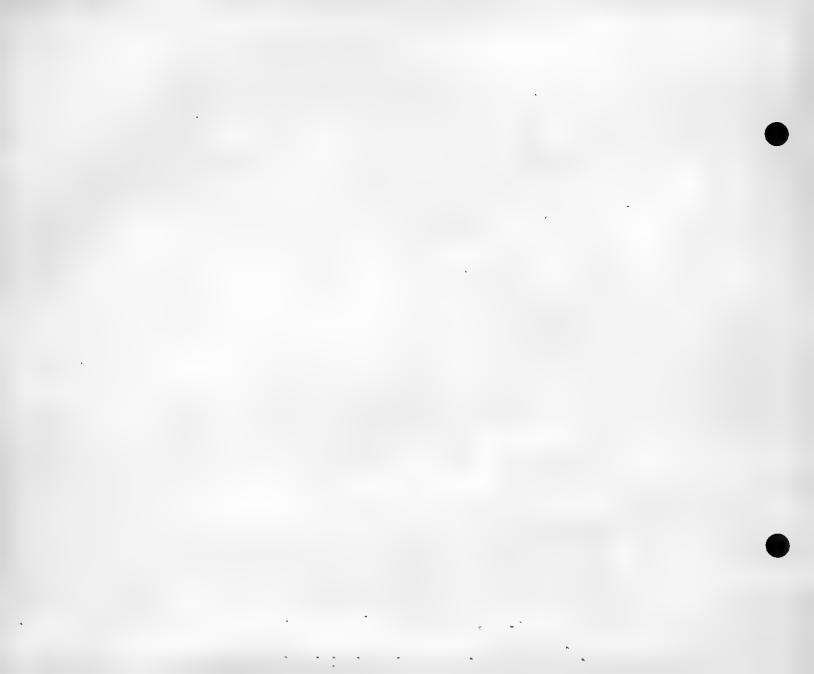


11255 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 1,256 2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH a. COUNTY b. COUNTY 3 Montgomery o. Swx Maryland 24 hours after MARYLAND b. CITY OR TOWN (If outside carparate limits C. LENGTH OF STAY IN 16 (CITY OR TOWN (If autside carparate limits, write RURAL and give negrest town) write RURAL and give nearest town) 4 days Accokeek d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Naval Hospital Route #1 Box 285 YES NO A The law requires that the death certificate be executed within NAME OF remove carban First Middle 4. DATE Month Last Yent. DECEASED (Type or print) OF Arice Burton MULLER 1967 8 George and in any event, DEATH S SEX 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED **NEVER MARRIED** AGE (In years IF JNDER 1 YEAR IF UNDER 24 HRS Hours Male Cauc 19 Dec 1920 WIDOWED DIVORCED and 10a USUAL OCCUPATION (Give kind of work dane 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT life even if retired) physician a ien please during most of werking COUNTRY U.S.A INDUSTRY IISN Bristol, Va. 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar remayal, Frederick Muller Bessie Jones Accoknek, Md. 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no. ar unknown) (If yes give war or dates of service) Juanita P. Muller Rt/1, Box 285 Accokek, No. 225-03-3795 burial, crematian, 18 CAUSE OF DEATH (Enter anty one cause per line for (a) (b), and (c),) INTERVAL BETWEEN signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) Myocardial Infarction, Acute Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gave Arteriosclerotic Coronary Vascular Disease, rise to immediate couse (a), DUE TO Severe stating the underlying cause be detached far use as the State Dept. af Health prior to has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? CERTIFICATION NO 20a ACCIDENT WAS UNDERLYING □ 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part It of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (City or town) (County) (State) factory, street affice bldg., etc.) at work 3 August 1967 to 7 August 1967 that (1) (we) lost 21. I certify that (I) (this haspital) attended the deceased fram. be filed with the 7 August and that death accurred at 9:15PM, from causes and on the date stated above. 1907 O FUNERAL DIRECTOR: saw the deceased alive an 22a. SIGNATURE 22b DATE SIGNED STAFF PHYS. **ATTENDING** K 8 Aug., 1967 M.D. PHYS 22c. PHYSICIAN'S NAME (Type) 22d, ADDRESS Naval Hospital, Bethesda, Md. P:T: KIRCHNER 23d location (City or Town) Arlington, Va. 23c NAME OF CEMETERY OR CREMATORY 23a. BURIAL CREMATION 23b DATE THEREOF (County) (State) REMOVAL (Specify) Arlington, National Aug. 11-1967 25b REGISTRARS SIGNATURE WDC ADDRESS 2Sa REC'D BY REGISTRAR VR A15 (4) 25M 1/67 1967 Funeral Home 1661 Good Hope Rd. S.E.

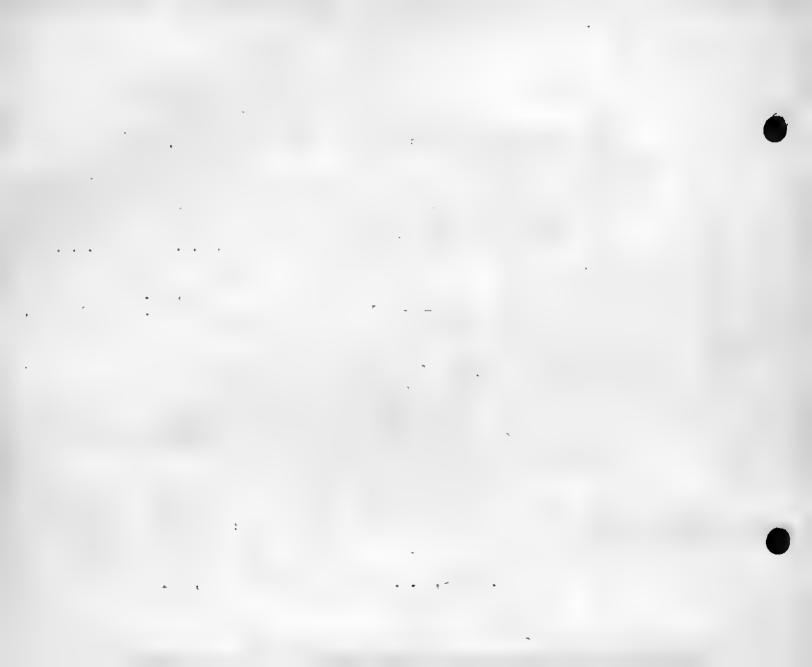
MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH O HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. deoth funeral puo PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY b. COUNTY in by the ... Pages 1 c MARYLAND ve carbón papers. Pages event, within 72 hours aft **b** CITY OR TOWN c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (If outside corporate limits, write RURAL and give nearest town SILVER d. STREET ADORESS d NAME OF HOSPITA, OR INSTITUTION (if not in haspital, give street address) IS RESIDENCE ON A FARM? filled i YES NO F NAME OF Middle DATE Fust Lost Month Day Year DISSAMID 2 (Type or print) 19 62 DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED Months Dovs Hours and in any WIDOWED DIVORCED 100. USBAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT physician a during most of working life, even if retired) INDUSTRY COUNTRY? 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or removal, IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give war or dates of service) No cremotion, 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN buriol-tronsit p moor you IMMEDIATE CAUSE (o) signed by Page 4 moy be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause be detoched for use os the Stote Dept. of Health prior to hos been PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPSY PERFORMED? YES NO this certificate 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Nat While foctory, street, office bldg., etc.) at work at work TO FUNERAL DIRECTOR: After 1967, that (1) (we) las 21. 1 certify that (1) (this haspital) attended the deceased from . 19 directar, page 3 should should be filed with the and that death accurred at 8:30AM, from causes and an the date stated above saw the deceased alive an. 22a. SIGNATURE 22b. OATE SIGNED STAFF PHYS. M.D. DIRECTOR PHYS 22d. AODRESS 22c. PHYSICIAN'S NAME (Type) 3737 24 95 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL, CREMATION, DATE THEREOF (Stote) (County) DEMOVAL (Specify) Suitland Md. Cedar Hill emetery 30.1967 2So. REC D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE **MODRESS** 24. FUNERAL DIRECTOR > VR A15 (4) 20 M 1/66 Ga. Hue. S.S. Pumphrey Inc.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours after deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY o. STATE Maryland b. COUNTY Montgomery MARYLAND Montgomerv b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 3h Silver Spring 2 days Olnev d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS] .7] "vatars the Imout New/ Pambahité/ Avé Montgomery General Hospital NAME OF Middle First 4. DATE Lost Month DECEASED OF and in any event, (Type or print) DEATH Marv Murphy nmn JE JNDER 1 YEAR S SEX 6. COLOR OR RACE B. DATE OF BIRTH 9 AGE (In years IF UNDER 24 HRS 7. MARRIED NEVER MARRIED remove Months lost birthdov) Hours WIDOWED 4 DIVORCED 5/29/86 female White 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) TOD KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT **COUNTRY?** housewife
13 FATHER'S NAME Washington, D.G.
14 MOTHER'S MAIDEN NAME H.S.A August Neibel Anna Aumet 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give you or dates of service) 16. SOCIAL SECURITY NO. Olney, Maddress 17. INFORMANT 6 Medical Records of Montg, General Hospit 215-54-7491 INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a) (b), and (c).) signed by the burial-tronsit p PART I. DEATH WAS CAUSED BY. NEDHONIA IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Page 4 may be retained by the hospital or attending 19 WAS ALTOPSY nos PART IL DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o). this certificate ٥ 20b DESCRIBE HOW INJURY OCCURRED, fenter nature of injury in Port I or Part II of item 18 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20e. PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INIJRY Month, Doy, Year 20d INJURY OCCURRED Hour o.m. Not While factory, street, office bldg., etc.) FUNERAL DIRECTOR: After 1967, that (1) (we) lost 23. I certify that (1)2(this haspital) attended the deceased from ______ with the 19 67, and that death accurred at 8:30 pM, from/causes and an the date stated above sow the deceased alive on 8 22g SIGNAZURE DIRECTOR . M.D. 22c. PHYSICIAN'S O HOSPITAL NAME (Type) Sandy Spring, Nd. Donald R. Lewis, M.D. director, should b 230 BURIAL CREMATION (County) 2 VR A15 (4) 25M 1/67



1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
	11255 CERTIFICATE OF DEATH 11259
=	PLACE OF DEATH o. COUNTY MARYLAND 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) o. STATE b. COUNTY Wash. D.C.
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
	Theaton 1 week 47.5
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e 15 RESIDENCE ON A FARM?
)[Iniversity Nursing Home 2526 South Dakota Ave., N.E. YES NO XX
	NAME OF First Middle Lost OF DECEASED (Type or print) MCKinley none Nicholson (Type or print) MCKinley (Type or
	SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9. AGE (n/eors lost birthdoy) Months Doys Hours Min.
ŀ	MINISTED WIDOWED DIVORCED 3712/1301 66 yrs
	to USUA. OCCUPATION (Give kind of work done Industry Industry State, or foreign country) 10 KIND OF BUSINESS OR INDUSTRY Saluda, South Carolina 12. CITIZEN OF WHAT COUNTRY? USA
	FATHER'S NAME 14 MOTHER'S MAIDEN NAME
	Jim Hill Lela
	(es, no, or unknown) (If yes give wor or dotes of service) 251-22-5710T John P. Nicholann, 2526 Fo. Dakote, Av., N. I
	IB. CAUSE OF DEATH (Enter only one couse per line for (v), (b), and (c).) PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a) Cong. Heart Joilure. Color Cong. Heart Joilure.
	Godding Have which are a DUE TO ASCATION
	the to immediate couse (a), stating the underlying couse (b).
	last. (c)
	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES \(\sigma \text{NOT} \) NO F
	20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)
	20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Hour a.m. 20f. (City or town) (County) (State)
l	21. I certify that (I) (this hospital) attended the deceased fram and 18, 1967, to any 29, 1947, that (I) (we) to
1	saw the deceased alive an any 26 1967, and that death accurred at 8000 M, from causes and an the date stated above
	220. SIGNATURE 22b, DATE SIGNED STAFF 22b, DATE SIGNED
.	MD. PHYS. DIRECTOR L PHYS. L COMES 4 1967
1	22d. ADDRESS Spring, Md. NAME (Type) Dr. Brookli Bufaling
	Dr. Rdssell Buldillo 1445 Dillvetsity Bivo. West Silvet
	So. BURIAL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote)
-	ADDRESS 7 A 250. REC'D BY REGISTRAR 25b, REGISTRAR'S, SIGNATURE
	Tutneys Funaral Hame 3831, La Tre Mu DAUG 31 1967 Icharles Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The law requires that the death certificate bs executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. COUNTY ON TOUTH ERY b. COUNTY MARYLAND Pages, b CITY OR TOWN (If eulside carparate units, write RURAL and give nearest term) c. CITY OR TOWN (If Curside corporate limits, write RURAL and give nearly town) c. LENGTH OF STAY IN 1b d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 15 RESIDENC ON A FARM YES NO K NAME OF DATE Year DECEASED (Type or pnnt) None DEATH 19 6 IF UNDER 1 YEAR 5 SEX 9. AGF (In years IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** birthday) Manths 11-21-96 гето WIDOWED X DIVORCED iigiled by the attillating physicion and co burial-tronsit permit. Then please rema burial, cremation, or removol, and in any 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? America during mast of warking life, even if retired) **INDUSTRY** touse wil 13. FATHER S NAME 14. MOTHER'S MAIDEN NAME 1 ACO 0 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NOT 17. INFORMANT (Yes, no, ar unknown) (If yes give war or dates af service) 18. CAUSE OF DEATH (Enter only one cause per line for INTERVAL BETWEEN PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) attending physicion. DUE TO Candifians, if any, which gave rise to immediate couse (a). DUE TO stating the underlying cause WAS AUTOPSY PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REMOVED TO THE TERMINAL DISEASE PERFORMED? NO certificote 20b DESCRIBE HOW INJURY OCCURRED. (Enter pature of injury in Part I or Part II of Item 18.) Page 4 may be retained by the hompital 20a ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) Hour a.m. factory, street, affice bldg., etc.) TO FUNERAL DIRECTOR: After ot work at wark 21. I certify that (1) (this hospital) attended the deceased fram director, page 3 should should be filed with the and that death accurred at Cook, from causes and saw the deceased alive on, on the date stoted above. 220 STGNATURE **PATE SIGNED**

CNAME (Type) Donald W. Datlow, M.D.

BURIAL, CREMATION,

24.7 FUNERAL DIRECTOR

ATTENDING

Y CEMETER Y

NAME OF CEMETERY OR CREMATORY

ADDRESS

DIRECTOR

Silver Spring, Maryland

University Blvd,

VILLE

(County)

(State)

23# LOCATION (City or Town)

VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11261 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY o. STATE COUNTY 3 to Page MARYLAND Maryland Montgomery b (ITY CR TOWN of autside tarporate limits, C LENGTH OF STAY IN 10 c CITY OR TOWN (Fautside carparate imits, write RURAL and give nearest tawn) P.M3. write RURAL and give nearest town) 45mins. Olney Md. d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE farm ON A FARM? Box. 179 Pages Montg omery General Hospital, Olney, Md YES NO X hours after death 3 NAME OF Middle 4 DATE along with First Last Month Day Year DECEASED OF Give (Type or print) Offutt August 19 67 Elias DEATH John IF UNDER 1 YEAR 1F UNDER 24 HRS S SEX 8 DATE OF BRITH 9 AGE (In years 6 COLOR OR RACE 7 MARRIED F NEVER MARRIED last purthday) Months Dovs Hours DIVORCED WIDOWED 4-1-12 10a USUA, OCCUPATION (Give kind of work dane during most of working life, even if retired) 10h, KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? U.S.A n penal in Examiners Janitor
13 FATHER S NAME Astro Comm. Lab Maryland 14 MOTHER'S MAIDEN NAME be executed within Elizabeth Randoff Samuel Offutt 1S WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) [(1f yes give war or dates of service) 16. SOCIAL SECURITY NO 17 INFORMANT ward "pending the Chief Medical event within No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per lipe for (a), (b), and (c).) PART I DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) ONSET AND DEATH burnal-transit This certificate shauld the ward DUE TO any Conditions, if only, which gove rise ta immediate cause (a), 0 .⊆ DUE TO e, writing the stating the underlying couse last PART I OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS AUTOPS Y PERFORMED? remaval, certificate, 20a. EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18.) 3 should PRIMARY ar CONTRIBUTING ŏ shaufd CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20f (City or town) (County) (State) Haur a.m. Nat While factory, street, affice bldg., etc.) may be retained far yaur FUNERAL DIRECTOR: Page at work at wark please execute 21 I certify that I took charge of the remains described above, held on Autopsy Inspect on 🔀 Inquiry X ond in my opinion death resulted from Natural causes Accident Suic de Homicide Undetermined manner funeral director CHIEF MEDICAL EXAMINER **ACTUAL** 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior SIGNATURE . DEPUTY MEDICAL EXAMINER EXAMINER'S O FUNE Health Address Street Rut Lewer or county) NAME (Type) 23d LOCATION CENETERY OR CREMATORY BUR AL CREMATION. REMOVAL (Specify, MT. ZION CEMETERY MONTG. 8/5/67 MT. ZION. ADDRESS 250 REC D BY REGISTRAR VR A15ME (5) 6M 1/67

/ 1	MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	11262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH
HEALTH DEPT.	1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)
184 54	OCCUNTY OMERY MARYLAND STATE Md. b. COUNTY Men Tignery
	b CITY OR TOWN-(If outside carparate limits, write RURAL and give nearest town)
f way delay many partment rs after deal	Silver Spring 4 days Wheg Ton Silver Spring
Dep as a	d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM?
Pages 1, v th form of the form	3 NAME OF FIRST MIDDLE LOST 14 DATE Massler Day Year
INER: This certificate should be executed within 24 hours after death. If it is certificate, writing the ward "pending" in penal, in Item 18. Give Pages 1, should be farwarded to the Chief Medical Examiner's Office along with form files. 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dent, priar to burial, cremation, ar remaval, and in any event with 2 hours.	3 NAME OF First Middle Lost 4 DATE Manth Day Year DECEASED (Type or print) (haries Falk ord Owens OFATH 196
after d 8. Give alang w with the	S SEX 6. CO. OR OR RACE 7 MARR FD TO NEVER MARRIED 1 8 DATE OF BIRTH. 9 ACE (1) years FUNDER 1 YEAR IF UNDER 24 HRS
12 a a a a a a a a a a a a a a a a a a a	My Widowed Divorced 18/ 2//33 Jost birthdoy) Months Days Hours Min.
Item 1 Office 1 and 2	100 USJAL OCCUPATION (Give kind of work done during most of working life, even if getired). 105 KIND OF BUSINESS OR 11. BIRTHFLACE (Stote or foreign country) 12 CITIZEN OF WHAT COUNTRY? 13 COUNTRY?
ncil in 24 niner's pages 1 in any	dung most of working life, even if getred) Lectrical mechanic 13 FATHER'S NAME 14 MOCHER'S MAIDEN NAME 14 MOCHER'S MAIDEN NAME
iffin encil	Gordon Owens Helen U. Powell
d with period of the period of	15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT
executed nding" i Medical permit.	(res, no, orunknown) If yes give wor or dotes of service) Yes Bertha Mae Owens Silver Spring, Maryland
certificate should be executed within writing the ward "pending" in pencil rewarded to the Chief Medical Examine used as a burial-transit permit. File page burial, cremation, ar remayal, and in a	18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), ong (c)) PART I DEATH WAS CAUSED BY ONSET AND DEATH
d be d "p Chief	, MMEDIATE CAUSE (o) STEELEST OF THE CAUSE (o)
should be en word "per or the Chief" burial-transit mation, or re	Cond trons, if ony, which gove) (b) Cerebral laceration incurred
te state of the date of the care of the ca	rise to immediate cause (a). stoting the underlying couse DUE TO
fical fing rded os o	(s) in auto accident,
his certific ate, writin e farwards be used as to burial,	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED?
MINER: This the certificate, 4 should be far files. 2,3 should be ugent, prior to light,	PERFORMED? YES NO NO 200 EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE HOW INJURY OCCURRED (Enjer noture of injury in Port I or Port II of item 18) CAUSE OF DEATH 200. TIME OF INJURY Month, Doy Yeor Add INJURY OCCURRED 200 PLACE OF INJURY (Home, form, 100; (City or town) (Caunty) (State) Cause of the place of the blade etc.) Cause of the place of the blade etc.)
NER: The certification hauld be lies. Should the should	200 EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enjer notice of injury in Port I or Port II of them 18) CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enjer notice of injury in Port I or Port II of them 18) CAUSE OF DEATH
EXAMINER. ute the cert age 4 shaul your files. Page 3 shau	20c. TIME OF INJURY Month, Doy Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20th (City or town) (County)
XAM te # your your age	pm) of work of pet att
AL EXA execute ir. Page if far you TOR: Pag	21 I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inspection , and my opinion
MkSrCA Slease ex director. etained if DIRECTO	deoth resulted from: Notural couses . Accident Suicide . Homicide . Undetermined monner .
Mk577 please directr directr retaine DIREC	SIGNATURE SIGNATURE ASSISTANT MEDICAL EXAMINER (22. DATE SIGNED
necessary, please execute the ce the funeral director. Page 4 shat 5 may be retained for your files 6 EUNERAL DIRECTOR: Page, 3 sh Health ar its designated agent,	EXAMINER'S BELDEN R READ M.D. DEPUTY MEDICAL EXAMINER & CHIQUEST 9, 1967
D DEPUTY necessary, the funers may be provided by necessary, the funeral provided by the function by t	230 BUR AL CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City of Gwn) (County) (Stote)
0 = = 0 E	Burial Prince Georges Co., Md.
VR A15ME (SOL	ADDRESS 250 REC'D BY REG STRAR 256 REGISTRAR'S SIGNATURE
6M 1/66	Warner & Pumphery Pro. Silver Spring, No. DATE AUG 17 1961 Illiantes Judge

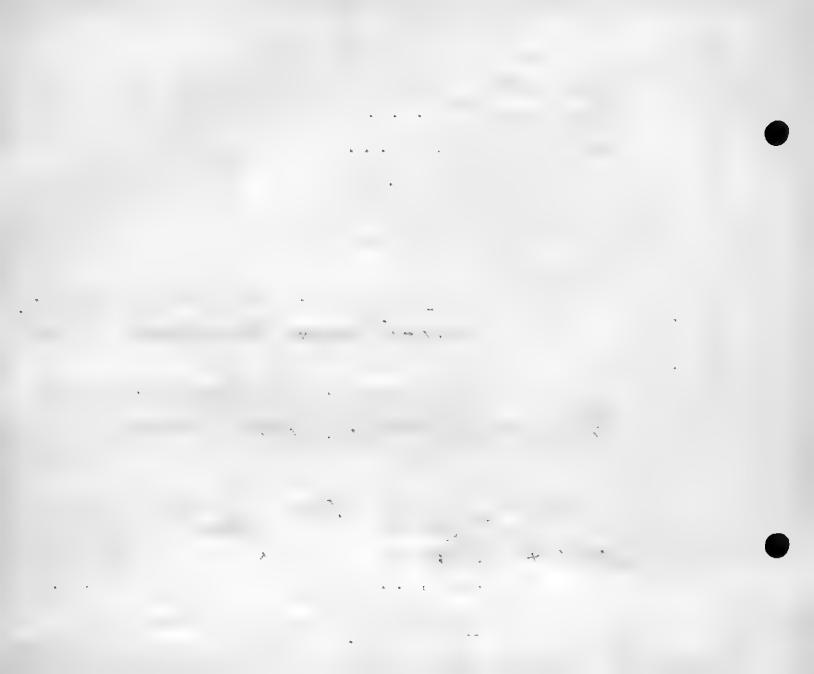


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11264 11263 CERTIFICATE OF DEATH death. The law requires that the death certificate be executed within 24 hours after death funeral and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits LINGTH OF STAY IN 16 c CITY OR JOWN (If outside comparate limits, write RURAL and give nearest town) write RURAL and give pegrest town) OR INST THE ON (If not in hospital, give street address) IS RESIDENCE ON A FARM? paper hin 72 NO X YES | NAME OF DATE DECEASED OF DEATH (Type or print) burial, crematian, ar remaval, and in any event S SEX AGE 6. COLOR OR BACE In years / MARRIED e/ Plast birthday Months Hours Davs WIDOWED DIVORCED remo 10a. USUAL OCCUPATION (Give kind at work done 1Db. KIND OF BUSINESS OR BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired)
Retired physician (nen please please Real Estate **COUNTRY ?** 13. FATHER'S NAM 14. MOTHER'S MAIDEN NAME the attending p WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO (Nephew) (Yes, na, ar unknown) (If yes give war ar dates of service) 1316 N.H.Ave., N.W None NTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY ONSET AND DEATH burial-transit IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician. DUE TO Canditions, if any, which gave (b) nse to immediate cause (a), DUE TO stoting the underlying couse certificate has been be detached far use as the State Dept af Health prarto (c) 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO T PHYSICIAN: 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 2Dd INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or tawn) (County) (State) 20c. TIME OF INJURY Month, Day, Year Hour a.m. factory, sereet, office bldg., etc.) at work 21. I certify that (I) (this hospital) ottended_the december from director, page 3 shauld shauld be filed with the sow the deceased olive on ... M. from coases and on the date stated above and that death accurred at 22g. SIGNATURE DATE SIGNED STAFF PHYS ATTENDING DIRECTOR FUNERAL 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Tawn) 230 BURIAL, CREMATION (State) REMOVAL (Specify) Burial Arlington National Cemetery Arlington. 2 250 REC D BY REGISTRAR **ADDRESS** 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Joseph Gawler's Sons, Inc., Washington, D.C.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH **OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death funeral 1 and 2 ter death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY. Alled in by ... Pages 1 a. 72 hours after d o. STATE b. COUNTY MonromeR Olney MARYLAND MARYLAND MONTGOMERY b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town) write RURAL and give nearest town) SWINERWSERN SILVER SPRING d. NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? thin 72 filled D.O.A. MONTGOMERY GENERAL HOSPITAL 2501 NORBECK ROAD YES X NO [ond completely fi remove corbon. NAME OF First Middle Lost 4 DATE Month Year BV BRAN DECEASED (Type or print) Eugene PARKER ORES DEATH AUGUST 5 19 67 SEX IF LNDER I YEAR IF UNDER 24 HRS 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years 7. MARRIED **NEVER MARRIED** lost birthdoy) Months Doys Hours MALE WHITE WIDOWED DIVORCED 6-24-97 70 ond in ony EXAM 10o LISUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (County & State or foreign country) during most of working life, even if retired) INDUSTRY COUNTRY? PLASTERER USA RETIRED TEXAS CAL 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removal, WILLIAM PARKER 6----BOYD E0 1 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) [(If yes give wor or dotes of service) Parker permit. FAMILY Dorothy No None 306-12-462**6**cremation, INTERVAL BETWEET 18 CAUSE OF DEATH (Enter only one couse per the for (o), (b), and (c), AP transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) þ ы α DUE TO signed | buriol, burial Conditions, if ony, which gove B rise to immediate couse (a). DUE stoting the underlying couse by the hospital or attending os the prior to peen last. >m WAS ALTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLIDING TO DEATH BUT NOT RELATED TO Heolth I LJ. EASE NO. certificate ig 20o ACCIDENT WAS UNDERLYING TO 206. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of Item 18) OR CONTRIBUTING CAUSE OF DEATH ō 딥 (IF EITHER, NOTIFY MEDICAL EXAMINER) Stote Dept. 01 됭 20c TIME OF INSURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) FOR Hour o.m. factory, street, office bldg , etc.) Not While of work of work I certify that (1) (this haspital) attended the deceased from Poge 4 moy be retained ED with the the deceased alive an 19.67, and that death accurred at a 504M from causes and on the date stated above TO FUNERAL DIRECTOR: AR 220 AGNATURE MED. DIRECTOR ATTENDING ш M.D. PHYS PHYS filed director, page should be filed 22d ADDRESS PHYSICIAN S O HOSPITAL NAME (Type) DONALD R. LEWIS, M.D. MEDICAL CENTER-SANDY SPRING. MD. 230 BURIAL, CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) REMOVAL (Specify) Rock Preek Cemetery Aug 11 BULLAR 250 REC'D BY REGISTRAR 25b. REG STRAR'S SIGNATURE FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Made AUG Juneral Home Silver Spring.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O. COUNTY NONTGOMERY MONTGOMERY MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after CLENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits. c CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) NAME OF HOSPITAL OR INSTITUTION (If not in hospitor, give street oddress) e IS RESIDENCE ON A FARM? d STREET ADDRESS ENOX NO TH YES NAME OF Middle First DATE Doy Year DECEASED OF DEATH HUGUST HORNTON (Type or print) 7, MARRIED **NEVER MARRIED** remove ast bythdoy) Months Dovs Hours and in ony WIDOWED DIVORCED OCCUPATION (G.ve kind of work done 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT ing most of work in lite, even if retired) STRICT FATHER'S NAME 14. MOTHER'S MAIDEN NAME or removol, EMMA HUYETT RKER HORNTON 16. SOCIAL SECURITY NO. INFORMANT DECEASED EVER IN U.S. ARMED FORCES? nknown) (If yes give wor or dates of service) cremation, INTERVAL BETWEEN
ONSELVAND DEATH CAUSE OF DEATH (Enter only one couse per ne for (o), (b) ond (c).) PART I. DEATH WAS CAUSED BY buriol-tronsit ABDOMINAL AORTIC IMMEDIATE CAUSE (o) by the hospital or ottending physician. DUE TO Conditions, if any, which gove (b) rise to immediate cause (o), DUE TO stoting the underlying couse prsor to as the 19. WAS AUTOPS'S
PERFORMED? PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) has NO I certificate ō 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATHdetached (IF EITHER, NOTIFY MEDICAL EXAMINER) director, page a successful bept should be filed with the State Dept 2Ge PLACE OF INJURY (Home, form, (Stote) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED ((ity or town) (County) Hour a.m factory_street, office bldg .etc) of work 21. I certify that (1) (this haspital) attended the deceased from JULY 29 1967 to Aug- 11 , 1967, that (I) (we) last saw the deceased alive on Jaly 29 1967, and that death accurred at 1.50AM, from causes and an the date stated above FUNERAL DIRECTOR: 220. SIGNATURE 22b. DATE_SIGNED MED
DIRECTOR M.D PHYS 22c. PHYSICIAN S TO HOSPITAL NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) BURIAL CREMATION 23b. DATE THEREOF (Stote) Cremation Cedar Hill Crematory Suitland 24. FUNERAL DIRECTOR Joseph Gawler's Sons. Inc. Wash., D.C.



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) PLACE OF DEATH a. COUNTY o. STATE b COUNTY Montgomery MARYLAND Maryland Montgomery Pers. Pages 72 hours after b CITY OR TOWN (If autside carparate limits, c. LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town)
Silver Spring Silver Spring e IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS ⊆. ON A FARM? 1.X 2209 Quinton Rd. YES □ NO □ Holy Cross Hospital 4 DATE NAME OF Middle Month Year DECEASED August 19 67 (Type or print) DEATH the death certificate be executed 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS B. DATE OF BIRTH SEX 6. COLOR OR RACE 7 MARRIED NEVER MARRIED last birthday) Days Hours 11/15/81 White WIDOWED 3 DIVORCED Male lease recharged 10g JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, eyen if retired)
Retired decorator INDUSTRY COUNTRY? Washington, L.C. 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME crematian, ar remaval, Charles Payne Laura Hill IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 22athhA 16 SOCIAL SECURITY NO (Yes, no, ar unknown) (If yes give wor or dates of service) 220-54-0190 Laura P. Diggs same as 18. CAUSE OF DEATH (Enter only one cause per line for (o) (b), god (c)) . INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Yuni IMMEDIATE CAUSE (o) DUF TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause be detached for use as the State Dept. of Health prior to 19. WAS AJTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT REPAYED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART NO X 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) 200 ACCIDENT WAS UNDERLYING [OR CONTR BUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, farm, 20d INJURY OCCURRED (City or town) (Caunty) (State) 20c TiME OF INJURY Month, Day, Year factory, street, affice blda, etc.) Hour a.m. Nat White at wark L. ot wark 21. I certify that (1) (this haspital) attended the deceased fram. 196 /, and that death accurred at 3 / AM, from causes and an the date stoted above saw the deceased alive an. 22b DATE SIGNED SIGNATURE ATTENDING STAFF 8/1/67 director, page 3 shauld be filed v 19th St., N.W. 22d ADDRESS PHYSICIAN'S James T. Estes, M.D. NAME (Type) Washington, D.C. 23d. LOCATION (City or Town) 23a BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) Gedar Hill Cemetery Suitland 0 Hines Company 25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH

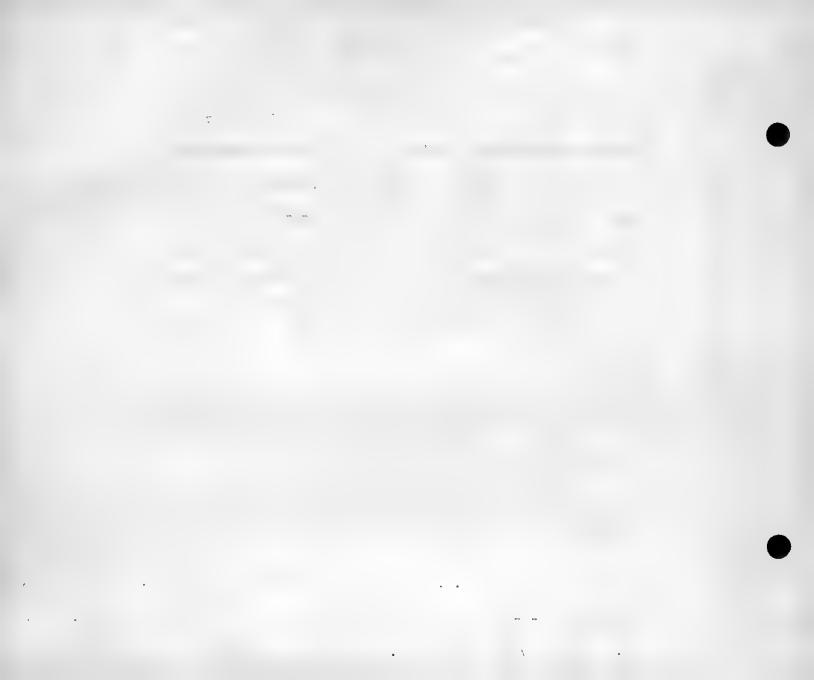


_	MARYLAND STATE DEPARTMENT OF HEALTH									
	DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
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TO DEPUTY MAIN NECESSORY, Pleos the funeral dire 5 may be retain TO FUNERAL DIRECTORY Health prior to	EXAMINER'S NAME (Type) JOHN G. BALL Address (Street city, town, or county) 230 BJALL (REMATION, BRANCH Specify) BUNDAL (Specify) BUNDAL (Specify) S-4-1967 FORT LINCOLN CEMETERY BLADENS BURG, MARYLAND									
VR A15ME (5)	24 FUNERAL D RECTOR 250 REC DRY REG STRAR 250 REG STRAR S SIGNATURE W.W. CHAMBERS GO PIVERDALE, MD DATE AUG 4 1967 June 250 REG STRAR S SIGNATURE DALE, MD DATE AUG 4 1967 June 250 REG STRAR S SIGNATURE									

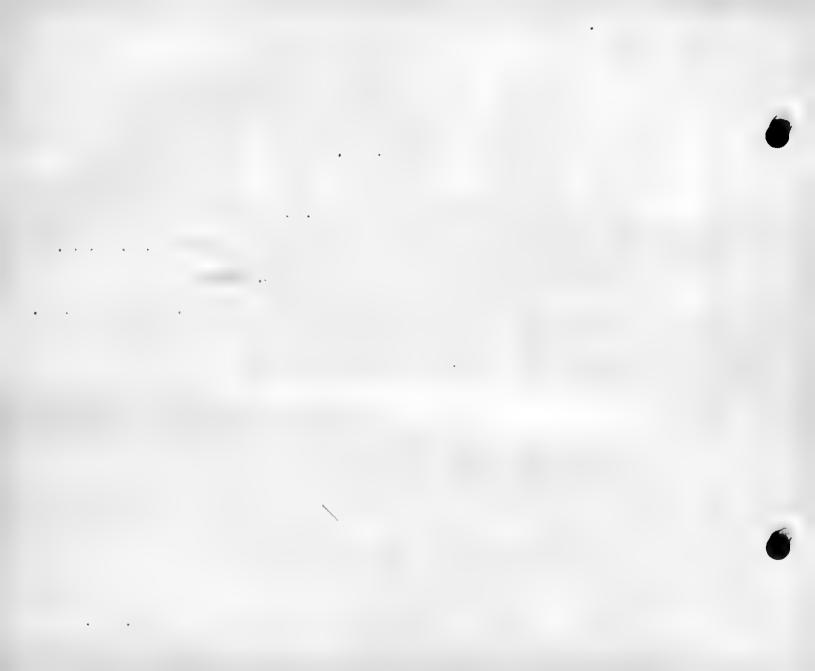
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11268 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admiss, on) 2, and PM3. Page o COUNTY **b** CRUNTY MARYLAND rince (7 Corge delay c CITY OR TOWN If autside corporate limits, write RURAL and give nearest tawhin State Department CLENGTH OF STAY IN 16 b CITY OR TOWN (If autside corporate limits write RURAL and give negrest town e. IS RESIDÊNCE ON A FARM? INSTITUTION (If not in haspital, give street address) ie certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2 should be farwarded ta the Chief Medical Examiner's Office alang with farm Give Pages 1, This certificate shauld be executed within 24 hours after death. If YES NO DO NAME OF Middle DATE DECEASED OF DEATH 400 (Type or print) 196 7 E UNDER 24 HRS 9 AGE (n years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED last buttiday) Manths in Item 18. 10-12-0 WIDOWED DIVORCED 10b. KIND OF BUSINESS OR 10a JSUAL OCCUPAT ON (Give kind of work done 12 CITIZEN OF WHAT 11 BiRTHPLACE (State or foreign country) 9 during most of working life even if retired) COUNTRY ? INDUSTRY any event within 72 haurs after irginia Supervisor 13 FATHERS NAME 14 MOTHER'S MATDEN NAME ie Sand 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknown) ((If yes give year ar dates of service 16 SOCIAL SECURITY NO 17. INFORMANT (Mrs.Sephie -58-8766 INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for) (a), (b), and (c). ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) the word DUE TO Conditions, if any, which gave rise to immediate cause (a), .≘ **DUE TO** D stating the underlying couse and last. be used 19 WAS AUTOPSY cremation, or remayal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PERFORMED CERTIFICATION the certificate, 20g. EXTERNA, CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury flat art I or Part II of item 18) 3 shauld PRIMARY I or CONTRIBUTING I CAUSE OF DEATH 20e PLACE OF INJURY (Home, form 20f (City or town) (State) 20d INJURY OCCURRED (County) 20c. TIME OF INJURY Month, Doy, Year Haur a.m. factory, street, affice bldg., etc.) 5 may be retained for your O FUNERAL DIRECTOR: Page Nat While ot work of work 21. I certify that I took charge of the remains described above, held an Autopsy Inspection | Inquiry and in my opinion priar ta burial, Notural causes Accident Socicide the funeral director. death resulted from Undetermined manner Hamicide CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Health Address Brock Lity town NAME (Type) 23d LOCATION (City of Town) 23b BURIAL, CREMATION Cedar Hill Comst:ry Suitland. 24. FUNERAL DIRECTOR NA 110 y 18 25a REC'D BY REGISTRAR ADDRESS: VR A15ME (5) 6M 1/67 Ha me Inc.



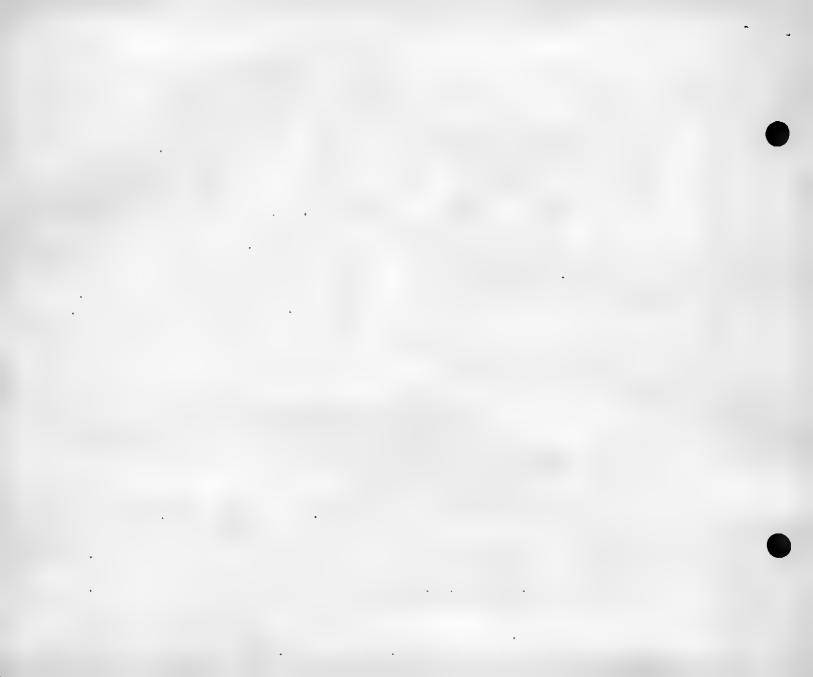
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he death cei attending p permit. The	(3,	s, no, or unknown) (If yes giv	e war or dates of se	rviće)	OCIAL SECURITY NO	1/ 1/	Father		Same			
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TO HOSPITAL OR ATTENDING Page 4 may be retained by the FUNERAL DIRECTOR: After 1 director, page 3 shauld be d shauld be filed with the State		226. SIGNATURE	1	18 EG	und	M.D	APPRINTING	MED STA	22b	DATE SIGNED	7	
PITAL O may be ERAL DIE ir, page		22c PHYSICIAN'S NAME (TYWalla	ce McCun	e, M.I) .		911 Silve	r Spring	Ave. Sil	ver Spi	cing, l	
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VR A15 (4)	2	. FUNERAL DIRECTOR			ADDRESS			BY REGISTRAR	25b. REGISTRAR	_		
25M 1/67		J. Ruffcon	cn, 7600	Carro	oll Ave.	Takoma	Park DATE A	UG 1 1 19	67 gcl	only &	udge	



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH The low requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission o. COUNTY a. STATE b. COUNTY Montgomery Maryland Propletely filled in by the fur yellor pages 1 yellor pages 1 eyent, within 72 hours after MARYLAND c LENGTH OF STAY IN 1b b CITY OR TOWN (If autoide carparate limits, c CITY OR TOWN (If auts de carparate limits, write RURAL and give nearest town) write RURAL and give nearest town) Forest Hill Gaithersburg Vears d NAME OF HOSPITAL OR INSTITUTION (14 not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? Asbury Methodist Home for the Aged, Inc. YES NO completely fi 3. NAME OF Middie First Last 4. DATE Manth Day Year DECEASED (Type or print) Gilbert Phelps Mary August 1967 DEATH S. SEX 8. DATE OF BIRTH 9. AGE (In years IF UNDER IF JNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED in ony eve last birthday) Manths Hours W Oct. 14, 1883 WIDOWED X DIVORCED 10b KIND OF BUSINESS OR 1Da USUAL OCCUPATION (Give kind of work done 12. CIT ZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired)
School teacher COUNTRY? INDUSTRY and Creswell, Harford Co.Md U.S.A 13. FATHER S NAME 14 MOTHER'S MAIDEN NAME buriol, cremation, or removal, Robert Jason Gilbert Anna S. ... 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, na, ar unknown) (If yes give war or dates of service Asbury Methodist Home, Gaithersburg, Md. 18. CAUSE OF DEATH (Enter only one couse per line for (a). PART I DEATH WAS CAUSED BY signed by 1 IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave nse ta immediate cause (a), DUE TO stating the underlying cause the hospitol or ottending this certificate has been be detached for use as the State Dept. of Heolth prior to 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CATION YES NO 20g. ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 2Dd INJURY OCCURRED 2De. PLACE OF INJURY (Hame, form, (City or fown) (County) (State) 2Dc TIME OF INJURY Month, Day, Year Hour om. Not While factory, street office bldg., etc.) at wark Page 4 may be retained by 2! I certify that (1) (thus hospital) attended the deceased from ___, that (I) (we) last to. OAM, from couses and an the date stated above. DIRECTOR: saw the deceased alive an and that death accurred at XS 22o. SIGNATURE 22b DATE SIGNED DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S SCRUGG NAME (Type) director, shauld b 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23a BURIAL CREMATION, (County) (Stote) 8/9/67 Mount Zion Cemetery Harford Co., Md. 0 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 1967 DATE AUG



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH HOR S 2 USUAL RESIDENCE (Where deceased lived, funshtution Residence before admission) 1. PLACE OF DEATH o. COUNTY o STATE b COUNTY / delay is and 3 ta 2, and Page MARYLAND State Department b CITY OR TOWN (If outside corporate limits C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest tawn) DOA. Loutons Ville. d NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) Sive Pages 1, 2, d STREET ADDRESS ON A FARM? Pages □ NO F MEDICAL EXAMINER: This cert ficate should be executed within 24 hours after death 3 NAME OF Middle DATE DECEASED Deatrice (Type or pont) DEATH S SEX B DATE DE BIRTH IF UNDER 1 YEAR COLOR OR RACE MARR ED AGE (In years NEVER MARRIED the certificate, writing the ward 'pending' in peacil in Item 18 4 should be farwardad to the Chief Medical Examiner's Office ald Months DIVORCED any event within 72 hours after death burial-transt permit file pages land 2 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even thetired)

5. OUSEVIOR k BIRTHPLACE (Stole or foreign country) 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT INDUSTRY 13. FATHER'S NAME 15 WAS DECEASED EVER IN L. S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yel, Decorporation) (fives give wor or dotes of service) 220-07-8274 17 INFORMANT Hattie Jones, Seaford, Delaware IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY. ONSET AND DEATH Hazel Injuly Severe -IMMED ATE CAUSE (b) Auto Accident DUF TO (and tions, if any, which gove) rise to immediate couse (a), DUF TO stating the underlying couse may be retained far yamr files. FUNERAL DIRECTOR: Page 3 shauld be used PART II OTHER'S GNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT RELATED TO THE TERM NAU DISEASE CONDITION GIVEN IN PART 1(a) 19 WAS ALTOPS crematian, or remayal, PERFORMED? MEDICAL CERTIFICATION 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) PRIMARY TO or CONTRIBUTING
CAUSE OF DEATH Passenger-in ear Ran of Road 20d NJURY OCCURRED 20e PLACE OF INJURY (Home form, (City or town) , (Stote) 20c. TIME OF NJURY Month, Doy, Year (County) factory, street, office bldg., etc.) While of work of work R. LOYFOITSVILLE MOINT-21 I certify that I took charge of the remains described above, held an Autapsy [X], Inspection , Inquiry , and in my apinian the fumeral director. Natural causes , Accident , Su cide , Hom cide , Undetermined manner [death resulted fram: CHIEF MEDICAL EXAMINER 22 DATE SIGNED 5 may be retr TO FUNERAL DI Health prior t ASSISTANT MED CAL EXAM NER SIGNATURE DEPUTY MEDICAL EXAMINER 54 **EXAMINER'S** NAME (Type) Address (Street, city, town, or county) 230 BURIAL, CREMATION 23b DATE THEREDE 23c. NAME OF CEMETERY DR CREMATORY 23d LOCAT ON (City or Town) (County) Aug. 9.1967 "ew Chapel Cemetery Near Easton, Maryland 250 RECD BY REGISTRAR 1967 256 REGISTRAR'S SIGNATURAL AUG 18 1967 24. FUNERAL DIRECTOR ADDRESS Crown Thamplan VR A15ME (5) DATE AUG 6M 1/67 Federalshure, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 2574 CERTIFICATE OF DEATH signed by the attending physician and campletely filled in by the funeral burial-transit permit. Then please remove corban papers. Pages 1 and 2 burial, crematian, ar remaval, and ig any eyent, within 72 haurs often death. requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. COUNTY outgomer MARYLAND MANTERNER b CITY OR TOWN (If outside Corporate limits. E LENGTH OF STAY IN 16 corparate limits, write RURAL and give hearest tawn) write RURAL and give negrest town) Wintersville Ohio akoma. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) any eyent, within NAME OF 4 DATE Year DECEASED OF (Type or print) DEATH 6 COLOR DRARACE 7 MARRIED NEVER MARRIED 9. AGE (In years last birthday) WIDOWED 🔀 DIVORCED 26 TOO USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHA during most of working life, even if retired) 13. FATHER'S NAME Morrison Bertson 1604 Neeley Kd 16 SOCIAL SECURITY NO (Yes, no, or unknown) i(If yes give war ar dates of service my + Hosts Silver Smarked, achoexa 1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), PART I. DEATH WAS CAUSED BY. INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) by the naspital ar attending physician. DUE TO enio sellino Cric ball 22 Conditions, if any, which gave nse ta immediate cause (a), or it cance DUE TO stating the underlying cause detached far use as the te Dept, of Health priar ta O FUNERAL DIRECTOR: After this certificate has been WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NDT RELATED TO THE TERMINAL DISEASE COND TON GIVEN IN PART 1(o) ATTENDING PHYSICIAN: The conjective NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 1B.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF NJURY Month, Dov. Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, farm, (City or tawn) (State) (Caunty) Haur a.m. factory, street, office bldg. etc.) Not While director, page 3 shaula be ae shauld be filed with the State at wark . 19 67 , ta d 21 | certify that (1) (this haspital) attended the deceased from 5 - 10 , 1962, that (I) (we) last be retained saw the deceased alive an 8-28 1967, and that death accurred at 128 PM, from causes and an the date stated above 220 SIGNATURE 22b DATE SIGNED STAFF MD PHYS 22d ADDRESS 22c PHYSICIAN'S Page 4 may TROOSA NAME (Type) Sicus 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 23b DATE THEREOF 230 BURIAL, CREMATION, (County) (State) REMOVAL (Specify) Forest Hill Cemetery Napoleon rans-Suria Ave. 250 RECD BY REGISTRAR 6 250 RECISTRAR'S SIGNATURE VR A15 (4) 25M 1/67 Silver Spring, DAR DE Funeral Home



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11275 CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE b. COUNTY ofter OR ATTENDING PHYSICIAN: The law requires that the deoth certificate be executed within 24 hours aftga MARYLAND b. CITY OR TOWN c LENGTH OF STAY IN 16 CITY OR TOWN write RURAL or son papers. Pog within 72 hours in by d NAME OF HOSPITAL OR ASTITUT ON (If not in hospital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? filled YES NO pou NAME OF Middle 4. DATE First Lost completely Doy Year **DECEASED** and in on event, carl (Type or print) DEATH 196 > S. SEX OLOR OR RACE IF UNDER 1 YEAR 24 HRS 7 MARRIED **NEVER MARRIED** DATE OF BIRTH AGE (In yeor JF UNDER lost birthdov) Months Doys Hours WIDOWED DIVORCED 100 USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR BIRTHPLACE (County, & State, or foreign country) 12 CITIZEN OF WHAT during most of Prorking life, even if retired) INDUSTRY signed by the attending physician buriol-tronsit permit. Then please COUNTRY 3 13. FATHER'S NAME 14 MOTHERS MAIDEN NAME or removal, 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no. grynknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT e dos a cremation, CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY PINSET AND IMMEDIATE CAUSE (o) Page 4 may be retained by the haspital or attending physician. DUE TO buriol, Conditions, if any, which gave rise to immediate couse (a), DUF TO stating the underlying couse os the prior to has been last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS' PERFORMED? for use Health r NO this certificate YES 200 ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 1B.) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f (City or town) (County) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) O FUNERAL DIRECTOR: After of work L 21. I certify that (1) (this hospital) attended the deceased from 2 1967, that (I) (we) lost and that death occurred at 12 9 PM, from causes and on the date stated above. saw the deceased alive on 3 220 SIGNATURE 22b. DATE SIGNED ATTENDING director, page 3 should be filed v M D PHYS DIRECTOR PHYS 22d. ADDRESS 4743 22c PHYSICIAN'S W. Bernton, M.D. Horace NAME (Type) Bradley Blvd. Chevy Chase, Md. NAME OF CEMETERY OR CREMA 230. CREMATION 23b VAL (Specify) REC'D BY REGISTRAR VR A15 (4) 25M 1/67

Example 1 and a second of the second

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11276 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours ofter death. the funeral pub PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) p. COUNTY b. COUNTY TOPLADMEN o. STATE MARYLAND C. LENGTH OF STAY IN 16 b CITY DR TDWN (If outside corporate lim.) c CITY OR TOWN (If outside corporate amits, write RURA, and give nearest town) papers. Pog Inn 72 hours (write RURAL and give nearest town) 60 days in by d NAME OF, HOSP TAL OR INSTITUT ON (If not in hospitol, give street oddress) Filled NAME OF Middle DATE Month Dov Year DECEASED (Type or print) DEATH TUGUST 1967 eve S. SEX 6. CDLDR OR RACE IF UNDER I YEAR NEVER MARRIED DATE OF BIRTH 9. AGE IF UNDER 24 HRS 7. MARRIED n veors remove last birthday) Manths Doys Hours and in any WIDOWED DIVORCED physicion and cone 10a USUAL DCCUPATION (Give kind of work done 10b. KIND DE BUSINESS DR 1. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during gnost of working life, even if retired) INDUSTRY Ohio College ibrarian 13 FATHER'S NAME 14. MDTHER'S MAIDEN NAME or removol, S. Powell Unknown offending poermit. The 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Campany Bank Avenue -10-9385A cremation, 18. CAUSE OF DEATH (Enter only one couse per line for (d), (b), and (c) NTERVAL BETWEEN burial-tronsit burial, cremat ONSET AND DEATH PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 10714nu signed DUE TO Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO s certificate has been s oched for use as the b ept. of Health prior to b stoting the underlying couse by the hospital or attending last. PART II, OTHER SIGNIFICANT CONDITIONS CONFRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART II, 19. WAS AUTOPS!
PERFORMED? CERTIFICATION NO PC 20a ACCIDENT WAS JNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18) detoched for the Dept. of F OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF NJJRY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form (County) (City or fown) (Stote) Hour o.m. Not While foctory, street, office bldg., etc.) After ot work of work 21 I certify that (1) (this haspital) attended the deceased from 1967, that (I) (wet last 19.50 to be retained TO FUNERAL DIRECTOR: and that death accurred at 0145 h Ham causes and on the date stoted obove saw the deceased alive on 19 0 220. SIGNATURE 225. director, page 3 should be filed v DIRECTOR PHYS 22c PHYSICIAN'S Page 4 moy NAME (Type) 23c NAME OF CEMETERY OR CREMATORY 23d LOCAL ON (City of Town) 230. BUR-AL CREMATION. 23b DATE THEREOF (Stote) REMOVAL (Specify) Riverside Cemetery iance 250. REC D BY REGISTRAR VR A15 (4) 25M 1/67 MarylandoATFAU Spring.



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH ner 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. COUNTY b. COUNTY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b ver 5 prina completely filled in ove carbon papers. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM? 2242 49th St. Nsa Home NOK YES executed within NAME OF Month Day Year Middle DATE Last DECEASED 0F Fredenck 1967 August ohn reston DEATH (Type or print) AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) Months | Days | Hours | Min. 5. SEX 6. COLOR OR RACE 8. 9, етоме 7. MARRIED NEVER MARRIED Months Days Hours any WIDOWER DIVORGED physician a in please re val, and in a 12. CITIZEN OF WHAT 10e. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR (County & State, or foreign country) during most of working life, even if retired) COUNTRY? certificate be INDUSTRY 1550UTI 4.5. Count .S. A. removal, FATHER'S NAME MOTHER'S MAIDEN NAME attending parmit. Then Virginia William 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address 16. SOCIAL SECURITY NO. been signed by the attenthe burial-transit permit. It to burial, cremation, or death (Yes, no, or unkown) | (If yes give war or dates of service) NENT B. Greenley Takema Tait 811 Houston CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN PHYSICIAN: The law requires that the the hospital or attending physician. ONSET AND DEATH PART I. DEATH WAS CAUSED BY: HES INCUMONIA IMMEDIATE CAUSE (a DUE TO EREBRA-Vascular Conditions, if any, which (b) gave rise to immediate DUE TO PRATIC VASCULAR DISEASC (a), stating the 0 r this certificate has be detached for use as to the Dept. of Health prior underlying cause last. (C) CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(2) 19. WAS AUTOPSY PERFORMED? YES NO DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part I or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING I OR CONTRIBUTING [] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) O FUNERAL DIRECTOR: After the director, page 3 should be de should be filed with the State Hour a.m. Not While ATTENDING be retained by at work 19 at work p.m. 66 21. I certify that-(1) (this hospital) attended the deceased from and that death occurred at 8:40 PM, from the causes and on the date stated above. saw the deceased alive on. DATE SIGNED 22h. 22a. SIGNATURE ATTENDING PHYS. DIRECTOR PHYS M.D. FO HOSPITAL OF PAGE 4 may **ADDRESS** 22c. PHYSICIAN'S 22d. NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) JREC'D BY REGISTRAF FUNERAL DIRECTOR Gawler' Sons. Inc. VR A15 (4) 15M 4-64

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11277 11278 CERTIFICATE OF DEATH after death pup PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased fived, if institution: Residence before admission) o. COUNTY b COUNTY o. STATE Montgomery MARYLAND Montgomery b. CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) an papers. Pag within 72 haurs 18 days Brookeville d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress) e. IS RESIDENCE ON A FARM? d STREET ADDRESS completely filled in YES - NO Montgomery General Hospital Rt. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within carban 3. NAME OF Middle Lost 4. DATE Month Doy Year DECEASED OF William Priebe 19 67 (Type or print) August DEATH S. SEX 6. COLOR OR RACE 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED **NEVER MARRIED** гетточе lost birthdoy) Months Days Hours in any WIDOWED DIVORCED Malel White pup 10o. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life, even if retired) COUNTRY? physician o THE WAY U.S.A Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remayal, Fibelkorn Herman Priebe Bertha 17. INFORMANDIney, Md. IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address (Yes, no, or unknown) (If yes give wor or dates of service) 10 577-26-8837 Medical Records of Montg. General Hospit crematian, JNTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) burial-transit PART I, DEATH WAS CAUSED BY CEMIA IMMEDIATE CAUSE (o) FUNERAL DIRECTOR: After this certificate has been signed by DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUF TO stoting the underlying couse the haspital ar attending the WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) far use Health p PERFORMED? YES [NO 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) detached for OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) Hour 'o.m. Not While foctory, street, office bldg., etc.) of work Page 4 may be retained by . I certify that (1) (this hasnital) attended the deceased fram 6/, that (1) (we) los with the and that death occurred at 10 % M, from causes and an the date, stated above the deceased alive on 220.7SIGNATURE M.D. DIRECTOR 22d. ADDRESS PHYSICIAN'S O HOSPITAL NAME (Type) Donald Lewis Sandy Spring, Md directar, shauld b 23o. BURIAL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote (County) REMOVAL (Specify)
Burial Mt. Carmel 0 Sunshine Mont 24. FUNERAL DIRECTOR 25o. REC'D BY REGISTRAR VR A15 (4) Francis H. Barber Laytonsville, Md. DATAUG 25M 1/67

MELLONA KIDNEY TERRINI HOLETH MOLTIPLE HYELONA 34 / marks - dyllety in Camel all which endelsand Femela L - roce Lutensville, Md.